# SENTARA HEALTH PLANS

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

**Drug Requested: Increlex®** (mecasermin)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**DEA OR NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis**: _____ **ICD Code, if applicable**: _____

**Weight:** _____ **Date:** _____

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial Authorization: 12 months**

| **Diagnoses:** | | |
|---|---|---|
| ❑ Severe primary insulin-like growth factor-1 (IGF-1) deficiency | ❑ Growth hormone gene deletion | ❑ Other (please specify): |

| **Clinical Information:** | | | |
|---|---|---|---|
| **Pre-treatment height:** _____ | | **Pre-treatment age:** _____ | |
| **Pre-treatment IGF-1 value (normal range _____) (Less than or equal to 3 standard deviations below the mean for age and gender)** | | **Pre-treatment Growth Hormone Level (normal range _____) (Normal or elevated growth hormone levels)** | |
| **Date**: _____ | **Value**: _____ | **Date**: _____ | **Value**: _____ |

**(Continued on next page)**

- ❑ **For diagnosis of Growth hormone gene deletion:**
  - ❑ Neutralizing antibodies to GH ❑ Yes ❑ No ❑ DATE: _____

**Reauthorization: 12 months.** Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth rate velocity. Coverage for growth promotion will cease when the bony epiphyses have closed. Yearly reassessment for reauthorization of coverage is required

- ❑ If 16 years of age or older, provide appropriate **yearly** documentation to confirm epiphyses are not closed
- ❑ Growth rate velocity must be ≥ 2.5 cm/year

**Medication being provided by Specialty Pharmacy - PropriumRx**

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.***

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***