

INCRELEX (MEDICARE DETERMINATION)

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Is the patient 2 years of age or older? Y N
3. Does the patient have closed epiphyses? Y N
4. Does the patient have the presence of active or suspected neoplasia? Y N
5. Does the have a diagnosis of severe primary insulin-like growth factor-1 (GF -1) deficiency (Primary IGFD)? (e.g., mutation in the GH-receptor, mutation in the post-GHR signaling pathway, IGF-1 gene defects). Y N
[If the answer to this question is yes, then may skip to question 8.]
6. Does the patient have a diagnosis of growth hormone gene deletion? Y N

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7. Has the patient developed neutralizing antibodies to growth hormones? Y N
8. Has the patient received Increlex therapy for at least one year through a Caremark pharmacy benefit?
[If the answer to this question is yes, then may skip to question 11.] Y N
9. Was the height of the patient greater than or equal to 3 standards deviations below the norm for children of the same age and gender prior to beginning Increlex therapy? Y N
10. Does the patient have a basal IGF-1 level greater than or equal to 3 standards deviations below the norm for children of the same age and gender prior to beginning Increlex therapy?
[No further questions required.] Y N
11. Has the patient displayed an increase in height velocity of 2 cm/year within the first year of Increlex therapy? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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