Increlex

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Severe primary insulin-like growth factor-1 (IGF-1) deficiency
   - ❑ Growth hormone (GH) gene deletion with neutralizing antibodies to growth hormone
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Indicate **pre-treatment**: Height: _____ cm Age: _____ IGF-1 level (with range): _____/_____
4. Indicate **current:** Height: _____ cm Age: _____ IGF-1 level (with range): _____/_____
5. Are the epiphyses still open? ❑ Yes ❑ No ❑ X-ray not available
6. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #11*
7. Is the patient currently receiving Increlex through samples or a manufacturer's patient assistance program? *If Yes, skip to #12* ❑ Yes ❑ No
8. Please document/attach the following information provided by the prescriber:
   A) Total duration of treatment (approximate duration is acceptable): _____
   B) Date of the last dose administered: _____
   C) Approving health plan/pharmacy benefit manager: _____
   D) Date of the prior authorization/approval: _____
   E) **Attach** authorization approval letter
9. Is the patient growing by more than 2 cm/year? ❑ Yes ❑ No
10. Is there a clinical reason for the lack of efficacy? ***Indicate below and no further questions.***
    - ❑ On treatment for less than 1 year, *indicate duration:* _____ months
    - ❑ Nearing final adult height – in later stages of puberty
    - ❑ Other _____

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11. Is the pretreatment height 3 or more standard deviations (SD) below the mean for age and gender?
    ❑ Yes ❑ No
12. Is the pretreatment basal insulin-like growth factor-1 (IGF-1) level 3 or more standard deviations (SD) below the mean for age and gender? ❑ Yes ❑ No
13. Has pediatric growth hormone (GH) deficiency been ruled out with a provocative GH test? ❑ Yes ❑ No
14. What was the peak growth hormone level on the provocative test? _____ ng/mL

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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