08/26/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Increlex (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Increlex (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Increlex (mecasermin)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Does the patient have a growth velocity greater than or equal to 2.5 cm/yr and open epiphyses? Y N

   [If yes, no further questions.]

3. Has the patient experienced at least a doubling of pretreatment growth velocity? Y N

   [No further questions.]

4. Is therapy being prescribed by or in consultation with a pediatric endocrinologist? Y N

   [If no, no further questions.]

5. Is there evidence of epiphyseal closure? Y N

   [If yes, no further questions.]

6. Is there evidence of neoplastic disease? Y N

   [If yes, no further questions.]

7. Does the patient have a diagnosis of severe primary IGF-1 deficiency? Y N

   [Supporting documentation of diagnostic criteria and evidence that secondary causes of low IGF-1 have been ruled out (GH deficiency, malnutrition, hypothyroidism, or chronic use of pharmacologic doses of corticosteroids) should be submitted with request]

   [If yes, skip to question 9.]

8. Does the patient have a diagnosis of growth hormone (GH) gene deletion with development of neutralizing antibodies to GH? Y N

   [Supporting documentation of diagnosis should be submitted with request.]

   [If no, no further questions.]

9. Is the patient 2 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date