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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Increlex SGM 1740-A – 06/2024.

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?
   - ❒ Severe primary insulin-like growth factor-1 (IGF-1) deficiency, *Continue to 2*
   - ❒ Growth hormone (GH) gene deletion with neutralizing antibodies to growth hormone, *Continue to 2*
   - ❒ Other, please specify. _____, *Continue to 2*
2. Is this request for continuation of therapy?
   - ❒ Yes, *Continue to 3*
   - ❒ No, *Continue to 10*
3. Is the patient currently receiving Increlex through samples or a manufacturer's patient assistance program?
   - ❒ Yes, *Continue to 10*
   - ❒ No, *Continue to 4*
   - ❒ Unknown, *Continue to 10*
4. Is 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) Prior authorization approval letter? ***ACTION REQUIRED***: If Yes, collect medical records.
   - ❒ Yes, *Continue to 5*
   - ❒ No, *Continue to 5*
5. Are the epiphyses still open?
   - ❒ Yes, confirmed by X-ray, *Continue to 6*
   - ❒ Yes, but X-ray is not available, *Continue to 6*
   - ❒ No, *Continue to 6*
6. Is information on the patient's current height and age provided? Indicate height in centimeters and age in years. _____ cm _____ years
   - ❒ Yes, *Continue to 7*
   - ❒ No, *Continue to 7*
7. Is the patient growing at a rate of more than 2 cm/year?
   - ❒ Yes, *No Further Questions*
   - ❒ No, *Continue to 8*
8. Is there a clinical reason for the lack of efficacy?
   - ❒ Yes, *Continue to 9*
   - ❒ No, *Continue to 9*
9. Please indicate reason for lack of efficacy. If on treatment for less than 1 year, specify treatment duration in months.
   - ❒ On treatment for less than 1 year _____, *No further questions*
   - ❒ Nearing final adult height/in later stages of puberty, *No further questions*
   - ❒ Other, please specify. _____, *No further questions*

10. Are the epiphyses open?
    ❒ Yes, *Continue to 11*
    ❒ No, *Continue to 11*
11. Is the patient's pretreatment height and age provided? If Yes, indicate height in centimeters and age in years.
    _____ cm _____ years
    ❒ Yes, *Continue to 12*
    ❒ No, *Continue to 12*
12. Is the pretreatment height 3 or more standard deviations (SD) below the mean for age and gender?
    ❒ Yes, *Continue to 13*
    ❒ No, *Continue to 13*
13. 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, *Continue to 14*
    ❒ No, *Continue to 14*
14. Has pediatric growth hormone (GH) deficiency been ruled out with a provocative GH test?
    ❒ Yes, *Continue to 15*
    ❒ No, *Continue to 15*
15. Was the peak growth hormone level on the provocative test greater than or equal to 10 ng/ml?
    ❒ Yes, *No Further Questions*
    ❒ No, *No Further Questions*

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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720