

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}
Patient's ID {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

ICD-10 Code: _____ Diagnosis: _____

Prescribed Drug and Dosage Form: _____

Is a loading dose required: ☐ Yes ☐ No

Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

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. Is this request for continuation of therapy? ☐ Yes ☐ No *If No, skip to #11*
3. Is the patient currently receiving Increlex through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #11 ☐ Yes ☐ No ☐ Unknown
4. Is the following information provided by the prescriber? **ACTION REQUIRED: If Yes, collect medical records.**
☐ Yes ☐ No
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
5. Are the epiphyses still open?
☐ Yes, confirmed by X-ray ☐ Yes, but X-ray is not available ☐ No
6. Is the patient's current height and age provided? *If Yes, indicate height in centimeters.*
☐ Yes _____ cm ☐ No
7. Is the patient growing by more than 2 cm/year? ☐ Yes ☐ No

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Increlex [Growth Hormone] SGM - 7/2023.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

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8. 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 _____
9. Are the epiphyses still open?
☐ Yes, confirmed by X-ray ☐ Yes, but X-ray is not available ☐ No
10. Is the patient's current height and age provided? *If Yes, indicate height in centimeters.*
☐ Yes _____ cm ☐ No
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. Was the peak growth hormone level on the provocative test greater than or equal to 10 ng/ml? ☐ Yes ☐ No

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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