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MAGELLAN COMPLETE CARE

Prior Authorization

Increlex®

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

☐ **INITIATION OF THERAPY** – Complete form and submit all relevant supporting documentation.

-OR-

☐ **CONTINUATION OF THERAPY** – Complete form and submit supporting documentation which should include a growth chart demonstrating progression of growth since initiation of therapy.

Diagnosis: (Please check all that apply and submit supporting lab work and documentation.)

☐ **Increlex®** for patient with severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD) defined by

- Height standard deviation score ≤ -3;
- Basal IGF-1 standard deviation score ≤ -3; and
- Normal or elevated growth hormone level.

☐ **Increlex®** for patient with growth hormone gene deletion who has developed neutralizing antibodies to growth hormone. (Must submit supporting documentation.)

Complete Assessment

1. Is the patient a child older than two years of age with open epiphyses?	◯ Yes	◯ No
2. Is the patient receiving ongoing care from an endocrinologist? Is the current prescriber an endocrinologist?	◯ Yes	◯ No
3. Does the patient have growth failure related to growth hormone deficiency, malnutrition, hypothyroidism, or chronic anti-inflammatory steroid use? *(Thyroid and nutritional deficiencies should be corrected before initiation of Increlex®)*	◯ Yes	◯ No
4. Does the patient have active or suspect neoplasia?	◯ Yes	◯ No

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Fax or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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