

FLORIDA MEDICAID 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)																			
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Recipient's Full Name																													
Prescriber's Full Name																													
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Prescriber's NPI																													
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Prose	riber Phone Number Prescriber Fax Number																												
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☐ In	Initiation of Therapy – complete form and submit all relevant supporting documentation.																												
_	-OR-																												
	ontinuation of Therapy – complete form and submit supporting documentation which should include a growth chart																												
	demonstrating progression of growth greater than or equal to 2 cm total in one year and final adult height has not been reached.																												
Diagr	Diagnosos: (Please check all that apply and submit supporting lab work and documentation)																												
Diagnoses: (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:																												
	•		_					tion					A NID																
	•							devi owth							nan '	10nc	ı/ml d	on st	anda	ard G	a Ha	timu	latior	n tes	sts) ()R			
□ In	 Normal or elevated growth hormone level (greater than 10ng/ml on standard GH stimulation tests) OR Increlex® for patient with growth hormone gene deletion who has developed neutralizing antibodies to growth hormone. 																												
(Must submit supporting documentation.)																													
Complete Assessment:																													
1.	ls	s the	pat	ient	a ch	ild ol	der	than	two	yea	rs of	fage	with	n op	en e	piph	yses	?							□ Y	'es		No	
2.	, , , , , , , , , , , , , , , , , , , ,													_ □ Y	'es		No												
	endocrinologist?																												
3.																□ Y	'es		No										
hypothyroidism, or chronic anti-inflammatory steroid use? (Thyroid and nutritional deficiencies																													
4.		should be corrected before initiation of Increlex®) Does the patient have active or suspect neoplasia?															□ Y	'es		No									
Drees	Drogoriborio Signoturo:																												
	Prescriber's Signature: Date: REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart note												note	s), a	nd th	e m	ost re	ecen	— t										

Fax this form to 1-866-940-7328

copies of related labs. The provider must retain copies of all documentation for five years.

Pharmacy PA Call Center: 1-800-310-6826

02.01.2025

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