CVS caremark™ {{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.

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: {{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

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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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