

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
INCRELEX(mecasermin)

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

CRITERIA:

- Patient age >2 and <18. Must start therapy before age 16
- Diagnosis of growth failure
- Documented diagnosis of Primary IGF-1 Deficiency
- Normal to elevated GH level and IGF-1 level at or below -3.0 standard deviations from normal levels
- Must have a height stature less than the 5th percentile on the PHYSICAL GROWTH NCHS PERCENTILES CHART for correct age and sex.
- Secondary forms of IGF-1 deficiency (e.g. malnutrition, hypothyroidism, chronic anti-inflammatory steroid use) have been ruled out.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Documented improvement on the PHYSICAL GROWTH NCHS PERCENTILE CHART for correct age & sex

02/15/11

<http://health.utah.gov/medicaid/pharmacy>