



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Increlex

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for reauthorization?

☐ Yes

☐ No

Q2. Has the patient had a positive clinical response to therapy as indicated by a growth rate > 2 cm2/year, or there is a documented clinical reason for lack of efficacy (e.g., being on treatment for less than 1 year, nearing final adult height/late stages of puberty).?

☐ Yes

☐ No

Q3. Is documentation attached showing the patient has a diagnosis of severe primary IGF1 deficiency?

☐ Yes

☐ No

Q4. Is the diagnosis confirmed by: height standard deviation score of -3.0 or less, basal IGF-1 standard deviation score of -3.0 or less, AND normal or elevated growth hormone (GH)?

☐ Yes

☐ No



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Patient Name:

Prescriber Name:

Q5. Is documentation attached showing the patient has a diagnosis of growth hormone (GH) gene deletion and has developed neutralizing antibodies to GH?

☐ Yes

☐ No

Q6. Are epiphyses confirmed to be open?

☐ Yes

☐ No

Q7. Will Increlex be prescribed by or in consultation with an endocrinologist?

☐ Yes

☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2025