Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Increlex - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 the request for reauthorization of Increlex? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response?

☐ Yes ☐ No

Q3. Is documentation attached showing the patient has a diagnosis of severe primary IGF1 deficiency? If YES, go to 4. If NO, go to 5.

☐ 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)? If YES, go to 6.

☐ Yes ☐ No

Q5. Is documentation attached showing the patient has a diagnosis of growth hormone (GH) gene deletion and has developed neutralizing antibodies to GH? If YES, go to 6.

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☐ Yes ☐ No

Q6. Will Increlex be prescribed by or in consultation with an endocrinologist? If YES, go to 7.

☐ Yes ☐ No

Q7. Does the patient have closed epiphyses?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 12 Months ☐ Other

Q9. Additional Information:

Prescriber Signature

Date

v2026