Jefferson Health Plans

2024 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: □ 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. Request type:

☐ Initial - Go to 2 ☐ Continuation - Go to 3

Q2. Does the patient have a diagnosis of severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH and meets ALL of the following criteria:
A) Pretreatment height is greater than or equal to 3 standard deviations (SD) below the mean for age and gender
B) Pretreatment basal IGF-1 level is greater than or equal to 3 SD below the mean for age and gender
C) Pediatric GH deficiency has been ruled out with a provocative GH test (i.e., peak GH level greater than or equal to 10 ng/mL)
D) Epiphyses are open?
Please submit documentation.

☐ Yes ☐ No

Q3. For continuation of therapy, are ALL of the following criteria met:
A) The patient's growth rate is greater than 2 cm/year 2 or there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of

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puberty)
B) Epiphyses are open (confirmed by X-ray or X-ray is not available)?
Please submit documentation.

☐ Yes ☐ No

Q4. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request