Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Increlex (Mecasermin) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Increlex (Mecasermin) (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
INCRELEX 40 MG/4 ML VIAL

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the member 2 to 17 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the member have a diagnosis of short stature or dwarfism in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 4.

4. Does the member have a diagnosis of growth failure due to Growth Hormone (GH) gene deletion/deficiency/mutation or neutralizing antibodies in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the member have a diagnosis of growth hormone deficiency in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the member have low Growth Hormone (GH) levels [evoked GH less than or equal to 7 ng/mL] in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Does the member have a height standard deviation score less than or equal to -3.0 in the last 90 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

8. Does the member have a basal Insulin Growth Factor-1 (IGF-1) standard deviation score less than score less than or equal to -3.0 in the last 90 days? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, denied.

9. Does the member have a diagnosis of an open epiphysis in the last 90 days? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Does the member have a diagnosis of chronic renal disease (CRD), pituitary tumors, hypothyroidism, or chromosomal abnormalities in the last 730 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 11.

11. Does the member have a diagnosis of malignancy or malnutrition in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 12.

12. Does the member have a history of antineoplastics (specific for mecasermin) in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 13.

13. Does the member have chemotherapy current procedural terminology (CPT) codes on file in the last 365 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Is the dose less than or equal to 0.24 mg/kg/day? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

15. Is the request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 16.
If the answer to this question is no, approved for 365 days.

16. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 17.

17. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 18.

18. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.

If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date