Physician's Prior Authorization
Questionnaire for Increlex®

PATIENT'S NAME: ____________________ **ID#:** _______________ **DOB:** ______

Patient Address: ____

Increlex® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis (no codes please)? ____________________________________

2. For severe primary IGF-1 deficiency, does the patient have:
   a. Height standard deviation score <-3? ____Yes ____No
   b. Basal IGF-1 standard deviation score <-3? ____Yes ____No
   c. Normal or elevated growth hormone? ____Yes ____No

3. Does the patient have growth hormone gene deletion with neutralizing antibodies to growth hormone? ____Yes ____No

Please submit medical records to support the diagnosis. Increlex® will be shipped to the patient from a specialty pharmacy.

Physician's Signature	Date
Please **Print** Name	Fax Number
Please **Print** Physician's Specialty	Phone Number

Thank you for your assistance. Please contact Arkansas Blue Cross and Blue Shield at (501) 378-3392 if you have any questions or concerns. You also may fax your response(s) back to Arkansas Blue Cross at (501) 378-6980.

Sincerely,
Pharmacy Programs
Forms are also available online at http://usableadmin.abcbs.net/providers/PharmacyForms.aspx