Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Increlex
(mecasermin)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Increlex 10mg/ml vial

Dose and Directions for use: Quantity: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):
☐ Severe primary insulin-like growth factor-1 (IGF-1) deficiency
☐ Growth hormone (GH) gene mutation
☐ Other (please specify):

Clinical Information:

For all requests:
What is/was your patient's pretreatment age? _____
What is/was your patient's pretreatment height? _____ Date taken:
Are you patient's bony epiphyses open? ☐ Yes ☐ No Date taken:
Has your patient been treated with Increlex in the past? ☐ Yes ☐ No
(if yes) What date was Increlex therapy started? _____
(if *yes*) Has beneficial response been shown on a growth curve chart? ☐ Yes ☐ No
Current growth curve charts must be included with this request.
Is your patient also being treated with growth hormone for growth hormone deficiency (GHD)? ☐ Yes ☐ No

For the diagnosis of IGF-1 deficiency:
Pretreatment basal IGF-1 value: Normal Range: Date:
Pretreatment growth hormone level: Normal Range: Date:

For the diagnosis of Growth Hormone (GH) gene mutation:
Has your patient developed neutralizing antibodies to growth hormone? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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