Texas Medicaid/CHIP Vendor Drug Program
Texas Standard Prior Authorization Form Addendum
Increlex® (mecasermin)

In addition to the *Texas Standard Prior Authorization Request Form for Prescription Drug Benefits*, please complete the information below. This information is essential to processing the prior authorization for the selected drug. Incomplete forms or failure to submit this addendum may cause delays in patient care and/or prior authorization denial. **Please fax the completed Standard Prior Authorization Form and Addendum to (866) 469-8590 for Fee-For-Service patients.** If the patient is enrolled in managed care, please contact the appropriate health plan for forms and instructions.

SECTION I — PATIENT INFORMATION

NAME:	MEDICAID ID #:	DOB:

SECTION II — PRESCRIBER INFORMATION

NAME:	NPI#:	PHONE:

SECTION III — MEDICATION INFORMATION

1. Does the patient have a diagnosis of growth failure due to growth hormone gene deletion/deficiency/mutation or neutralizing bodies in the previous 730 days?	☐ Yes	☐ No
2. Does the patient have low growth hormone levels (evoked GH < 7 ng/ml) in the previous 730 days?	☐ Yes	☐ No
3. Does the patient have a height standard deviation score ≤ -3.0 in the last 90 days?	☐ Yes	☐ No
4. Does the patient have a basal IGF-1 standard deviation score ≤ -3.0 in the last 90 days?	☐ Yes	☐ No
5. Does the patient have a diagnosis of open epiphysis in the last 90 days?	☐ Yes	☐ No

SECTION IV — REVIEW

☐ Expedited/Urgent Review Requested

By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

_____ _____

Signature of Prescriber or Prescriber's Designee Date