

**PREAUTHORIZATION FORM**  
**Increlex™**  
 (mecasermin)

**Therapeutic use:** Treatment of children with severe primary insulin-like growth factor (IGF)-1 deficiency.

**Quantity Limit:** NA

**Authorization Period:** 12 months

Patient's name \_\_\_\_\_

Patient's ID# [ ][ ][ ][ ][ ][ ][ ][ ][ ] DOB [ ][ ] / [ ][ ] / [ ][ ][ ][ ][ ]

ICD-9 [ ][ ][ ][ ][ ][ ][ ][ ][ ] \_\_\_\_\_

Physician's name \_\_\_\_\_

Physician's Ph# ( [ ][ ][ ][ ] ) [ ][ ][ ][ ] - [ ][ ][ ][ ][ ] Fax# [ ][ ][ ][ ] - [ ][ ][ ][ ][ ]

Physician's signature \_\_\_\_\_ Date signed [ ][ ] / [ ][ ] / [ ][ ][ ][ ][ ]

Supervising Physician's name \_\_\_\_\_ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:

1.	Is the patient diagnosed with severe primary IGF-1 deficiency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has an endocrinologist followed the patient for at least 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Please complete the following data if applicable.		
	Height (cm): _____	Date: _____	
	Annualized growth rate (cm/yr): _____	Date: _____	
	GH stimulation test (peak): _____	Date: _____	
	IGF-1 (please include normal range): _____	Date: _____	
	Bone age: _____	Date: _____	

**This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.**