Insulin-Like Growth Factor-1 Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Endocrinologist ☐ Internist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Increlex **Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD code: _____ Secondary ICD code: _____ ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: ***(Please submit growth chart for the past 2 years for review)***

Please provide the following: Height (cm): _____ Weight(kg): _____ Date: ____/____/____

☐ Yes ☐ No Is there radiological evidence of epiphyseal closure?

☐ Yes ☐ No Is there evidence of neoplasia or intra-cranial hypertension?

For Initial Requests:

☐ Yes ☐ No Is there clinical evidence that the patient has growth failure with GH gene deletion?
→ ☐ Yes ☐ No Has the patient developed neutralizing antibodies to GH?

☐ Yes ☐ No Does the patient have insulin-like growth factor-1 deficiency (IGFD)?
→ IGF-1 concentration: _____ Date: ____/____/____
☐ Yes ☐ No Does the patient have a basal insulin-like growth factor-1 (IGF-1) standard deviation score (SDS) less than or equal to -3.0 for age and sex?
☐ Yes ☐ No Does the patient have a normal or elevated growth hormone (GH) [defined as stimulated serum GH level (peak level)] of greater than 10 ng/mL? Please provide information below:
Stimulating Agent: _____ Peak Response: _____ Date: ____/____/____
☐ Yes ☐ No Does the patient have a basal (unstimulated) serum GH level greater than 5ng/mL? Please provide information:
Serum GH level: _____ Date: ____/____/____
☐ Yes ☐ No Is the height standard deviation score (SDS) less than or equal to -3.0 for age and sex? SDS score: _____

For Continuation Requests:

☐ Yes ☐ No Has the final adult height been reached?
→ What is the patient's percentile of adult height? ____%

☐ Yes ☐ No Has the patient been on therapy for over a year?
→ Please indicate the height velocity growth (in centimeters) achieved during the previous 12 months of therapy: ____cm

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.