CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Increlex® (mecasermin)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis: ☐ 783.43 Short Stature/Growth Failure ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has severe primary insulin-like growth factor-1 deficiency (primary IGFD) ☐ Yes ☐ No
- Patient has height standard deviation score = -3.0 **AND** ☐ Yes ☐ No
- Patient has low levels of IGF-1 **AND** ☐ Yes ☐ No
- Patient has normal or elevated growth hormone ☐ Yes ☐ No
- Patient has growth hormone gene deletion who have developed neutralizing antibodies to growth hormone ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Increlex® (mecasermin)	☐ 10mg/1ml inj.			

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)