

Pharmacy Prior Authorization Form

Last Reviewed: Jan. 10

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Increlex™ (mecasermin)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Increlex Injection 10 mg/ml

Dose: _____

Start date: _____

Priority Health Precertification Requirements:

Authorization of Increlex requires:

- Diagnosis of severe primary insulin-like growth factor-1 deficiency or growth hormone gene deletion
- Increlex must be prescribed by or after consultation with a pediatric endocrinologist
- Age is 2 years to 65 years
- Severe primary insulin-like growth factor deficiency
 - Height standard deviation score is ≤ -3.0
 - Age adjusted basal IGF-1 standard deviation score is ≤ -3.0
 - Growth hormone concentration is normal or increased
 - Epiphyses are open
- Growth hormone gene deletion
 - Epiphyses are open
- Patient's bone age must be
 - Less than 16 years for males
 - Less than 14 years for females

Continuation of Increlex requires:

- Epiphyses are open
- Rate of growth with Increlex is faster than pretreatment rate of growth
- Patient's bone age must be
 - Less than 16 years for males
 - Less than 14 years for females

Please Complete the Following Information:

Diagnosis:

- Severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD)- ICD code: _____
- Growth hormone (GH) gene deletion- ICD code: _____
- Other: _____-ICD code: _____ Please provide rationale for use: _____

Patient's age: _____

Patient's weight: _____

Patient has been evaluated by (prescribed by or after consultation with) a pediatric endocrinologist:

- Yes
- No

Patient will be self injecting:

- Yes
- No

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

Section 1 – New requests:

Patient has been diagnosed with severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD)

- Height standard deviation score is ≤ -3.0
- Age adjusted basal IGF-1 standard deviation score is ≤ -3.0
- Growth hormone concentration is normal or increased
- Epiphyses are open

Patient has been diagnosed with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH

- Epiphyses are open

Section 2 – Requests for continuation of therapy:

Patient's epiphyses are closed:

- Yes – Rationale for use: _____
- No

Rate of growth is faster than pretreatment:

- Yes
- No – Rationale for use: _____

What is the patient's bone age? _____

Duration of Authorization:

If all precertification requirements are met approval will be granted for one year.

Dosing:

The recommended starting dose of Increlex is 0.04 to 0.08 mg/kg twice daily. If well-tolerated for at least one week, the dosage can be increased 0.04 mg/kg per dose to the maximum dose of 0.12 mg/kg twice daily.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX