



**Prescription Drug Coverage Determination Form**  
Growth hormone  
Increlex® (mecasermin)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-466-9854.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

- |                                                                                                                                                                                                                                                                                       |                              |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?<br>Diagnosis: _____ ICD-9 code _____                                                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Is the patient 2 years of age or older?                                                                                                                                                                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the patient have closed epiphyses?                                                                                                                                                                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does the patient have a diagnosis of growth hormone (GH) gene deletion confirmed with genetic testing?<br>If yes:<br>▪ Has the patient developed neutralizing antibodies to growth hormone confirmed with lab testing?                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Has the patient failed one growth hormone (GH) stimulation tests [failure is defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia]? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Prior to initiation of therapy, is the height of the patient greater than or equal to 3 standard deviations below normal for children of the same age and gender?                                                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

7. Prior to initiation of therapy, does the patient have a basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Has the patient received Increlex® therapy for the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient experienced an increase in height velocity of 2 cm/year within the first year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. If present, has the thyroid and/or nutritional deficits been corrected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have secondary causes of growth failure been ruled out (e.g. include malnutrition, chronic steroid treatment)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does the patient have the presence of active or suspected neoplasia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.