



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?
2. Is the patient 2 years of age or older?
3. Does the patient have closed epiphyses?
4. Does the patient have a diagnosis of growth hormone (GH) gene deletion confirmed with genetic testing?
5. Has the patient failed one growth hormone (GH) stimulation tests...
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?

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.