



Prescription Drug Coverage Determination Form

Increlex

Increlex® (mecasermin)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

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 patient 2 years of age or older? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the patient have closed epiphyses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the patient have a diagnosis of severe primary insulin-like growth factor-1 (IGF-1) deficiency? | <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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes: | | |
| ▪ 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 a growth hormone stimulation test? | <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.