



Increlex
(Mecasermine)
Prior Authorization Form

Express Scripts
Phone 800-417-8164
Fax 877-837-5922

| | | | | | | | |
|---|--|---------------|-------|--|---------|----------------|----------------|
| Last Name | | First Name | | Prescriber's Name | | Specialty | |
| Home Phone | | Work Phone | | Office Phone | | Office Fax | |
| Home Address | | City | State | ZIP | Address | | City State ZIP |
| SCAN ID number | | Date of Birth | | Est. Start Date | | Office Contact | |
| For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home | | | | Special Instructions (i.e. Non-English Speaking Patient, etc.) | | | |

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|-------------|------|------------|-------------|
| Medication: | | Diagnosis: | |
| Sig: | Qty: | Refills: | ICD 9 Code: |

| | | | | |
|---|-------|-----------------|-----------|--------------|
| Secondary/ Supplemental Insurance Company | Phone | Name of Insured | ID Number | Group Number |
|---|-------|-----------------|-----------|--------------|

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| 1. Is the diagnosis or indication for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with growth hormone (GH) gene deletion? If yes, continue to #2. If no, continue to #3. |
| 2. Does the patient have height standard deviation score ≤ 3.0 and basal IGF-1 standard deviation score ≤ 3.0 and normal or elevated GH? If yes, continue to #5. |
| 3. Is the diagnosis or indication for the treatment of growth failure in children with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH? |
| 4. Is diagnosis confirmed by laboratory or genetic testing? |
| 5. Will Increlex be used in patients with one of the following: <ul style="list-style-type: none"> a. In patients with secondary forms of IGF-1 deficiency, such as Growth Hormone (GH) deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids b. In patients with closed epiphyses c. In patients with active or suspected neoplasia d. In adult patients |
| 6. Is the patient at least 2 years of age? |
| 7. Is the prescription written or initiated by an endocrinologist? |
| 8. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review? |

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

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|---|---|
| <u>For Internal Use Only</u> | |
| <input type="checkbox"/> Approved <input type="checkbox"/> Denied Comments _____ | Reviewer's Initials _____ Decision Date _____ |