Prescriber Criteria Form

Increlex 2026 PA Fax 551-A v1 010126.docx
Increlex (mecasermin)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Increlex (mecasermin).

Drug Name:
Increlex (mecasermin)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion and has developed neutralizing antibodies to GH? [If no, then no further questions.]	Yes	No
2	Is the patient 2 years of age or older? [If no, then no further questions.]	Yes	No
3	Does the patient have open epiphyses? [If no, then no further questions.]	Yes	No
4	Is the patient currently undergoing treatment with the requested drug? [If yes, then skip to question 8.]	Yes	No
5	Is the patient's height 3 or more standard deviations below the mean for children of the same age and gender? [If no, then no further questions.]	Yes	No
6	Does the patient have a basal insulin-like growth factor-1 (IGF-1) level 3 or more standard deviations below the mean for children of the same age and gender? [If no, then no further questions.]	Yes	No
7	Did the patient have a provocative growth hormone test showing a normal or elevated growth hormone (GH) level?	Yes	No

	[If yes, then skip to question 9.] [If no, then no further questions.]		
8	Is the patient experiencing improvement? [If no, then no further questions.]	Yes	No
9	Is the requested drug being prescribed by or in consultation with an endocrinologist?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____