BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 11/15/18**
SECTION: DRUGS	**LAST REVIEW DATE: 11/15/18**
	LAST CRITERIA REVISION DATE:
	ARCHIVE DATE:

INCRELEX® (mecasermin) subcutaneous solution

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

INCRELEX® (mecasermin) subcutaneous solution (cont.)

Criteria:

- **Criteria for initial therapy:** Increlex (mecasermin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is an Endocrinologist

  2. Individual is 2 through 17 years of age

  3. A confirmed diagnosis of **ONE** of the following:
     - **Individual with growth failure from severe primary IGF-1 deficiency (IGFD)** and **ALL** of the following:
       - Height is 3 standard deviations or more below normal for age and sex of the individual
       - Basal IGF-1 level is 3 standard deviations or more below normal for age and sex of the individual
       - Normal or elevated growth hormone (GH) level

     - **Individual with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone** and **ALL** of the following:
       - Growth hormone levels are normal or low
       - IGF-1 levels are on the lowest 25% of reference laboratory's range

  4. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
     - Funduscopic examination
     - Preprandial glucose
     - Thyroid function tests

  5. There is no concurrent use with any growth hormone product

  6. There is **NO** evidence of **ANY** of the following:
     - Chromosome aberrations
     - Malnutrition
     - Secondary forms of IGF deficiency (e.g., growth hormone deficiency, hypothyroidism, chronic treatment with systemic anti-inflammatory steroids)

  7. There are **NO** contraindications.
     - Contraindications include:
       - Active or suspected neoplasia
       - Known hypersensitivity to mecasermin
       - Intravenous administration
       - Closed epiphyses (growth plates)

  Initial approval duration: 12 months

INCRELEX® (mecasermin) subcutaneous solution (cont.)

- **Criteria for continuation of coverage (renewal request):** Increlex (mecasermin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by an Endocrinologist

  2. Individual's condition has responded while on therapy
     - Response is defined as:
       - Final adult height has not been reached yet, but individual's height has increased at least 2 cm total growth in one year over the previous year (*previous year and current year height values must be submitted with date they were done*)

  3. Criteria for renewal or continuation includes **ALL** of the following:
     - There is documentation of the expected goal adult height
     - The epiphyses are still open

  4. Individual has been adherent with the medication

  5. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use
     - Contraindications as listed in the criteria for initial therapy section
     - Significant adverse effect such as:
       - Severe hypoglycemia or persistent hypoglycemia despite increased food intake, rescue medication, and dose adjustment of Increlex
       - Intracranial Hypertension
       - Severe Lymphoid Tissue Hypertrophy (tonsillar/adenoidal hypertrophy)
       - Slipped Capital Femoral Epiphysis (SCFE)
       - Progression of Scoliosis
       - Benzyl alcohol reaction – "gasping syndrome"

  6. There is no concurrent use with any growth hormone product

  Renewal duration: 12 months

Description:

Increlex (mecasermin) is an injectable solution of human insulin-like growth factor-1 produced by recombinant DNA technology. Increlex is used for the treatment of growth failure in children with severe primary insulin-like growth factor (IGF-1) deficiency, also referred to as primary IGFD. These children have normal or elevated levels of growth hormone but due a deficiency of IGF-1, are unable to utilize the growth hormone resulting in extremely short stature. Increlex is also used in children with a growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. It is not a substitute for GH for approved GH indications.

Severe Primary IGFD includes classical and other forms of growth hormone insensitivity. Patients with Primary IGFD may have mutations in the GH receptor (GHR), post-GHR signaling pathway including the IGF-1 gene.

INCRELEX® (mecasermin) subcutaneous solution (cont.)

However, they are not GH deficient, and therefore, they are not expected to respond adequately to exogenous GH treatment.

Increlex is not intended for use in subjects with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids. Thyroid and nutritional deficiencies should be corrected before initiating Increlex treatment. Increlex is not a substitute for GH treatment.

Definitions:

Severe primary IGF-1 deficiency is defined by:
- Height standard deviation score less than or equal to –3.0 for age and sex of the individual
- Basal IGF-1 standard deviation score less than or equal to –3.0 for age and sex of the individual
- Normal or elevated growth hormone

Resources:

Increlex (mecasermin) product information accessed 11-02-18 at DailyMed: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a8b27a1b-a611-4f91-ad22-76d4b390c3ae

1. CenterWatch. Drugs Approved by the FDA Drug Name: Increlex (mecasermin). Updated 06/20/2008

2. Lewis ME, Neff NT, Contreras PC, et al. Insulin-like growth factor-I: potential for treatment of motor neuronal disorders. *Exp Neurol.* 1993 Nov;124(1):73-88

3. Mohamed-Ali V, Pinkney J. Therapeutic potential of insulin-like growth factor-1 in patients with diabetes mellitus. *Treat Endocrinol.* 2002;1(6):399-410

4. Tercica, Inc. Increlex Efficacy. Accessed 08/25/2008

5. Williams RM, McDonald A, O'Savage M, Dunger DB. Mecasermin rinfabate: rhIGF-I/rhIGFBP-3 complex: iPLEX. *Expert Opin Drug Metab Toxicol.* 2008 Mar;4(3):311-324

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.