

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

INCRELEX (mecasermin - rDNA origin)

Prescriber must be an endocrinologist.

Coverage Criteria

All FDA approved indications not otherwise excluded from Part D **and** child between 2 and 20 years of age.

Required Medical Information

Prior to starting therapy, a height > 3 SD below the mean for chronological age and sex **and** an IGF-1 level \geq 3 SD below the mean for chronological age and gender **and** one stimulation test showing patient has a normal or elevated GH level.

Continuation of Tx: increase in height velocity by greater than 2.5 cm total growth in one year **and** patient has open epiphyses.

Exclusion Criteria

Benzyl alcohol hypersensitivity; epiphyseal closure; IV administration of Increlex; active malignancy; use in neonates; concurrent use with GH therapy; secondary causes of IGF-1 deficiency.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			



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Requested Drug			
INCRELEX	Reason for Request		
Condition/Diagnosis Related			
Clinical Drug/Lab History Pertinent to Request			
Labs: Baseline/Ongoing		Strength/Dosage	
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			
Comments			

Physicians Signature: _____ Fax Form to 1-866-481-3704