TEXAS MEDICAID
Clinical Edit Prior Authorization
mecasermin (INCRELEX)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client 2 to 17 years of age?

   ☐ Yes (Go to # 2) ☐ No (Deny)

2. Does the client have a diagnosis of short stature or dwarfism in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Go to #3)

3. *Manual Step* - Does the client have a diagnosis of growth failure due to growth hormone (GH) gene deletion/deficiency/mutation or neutralizing antibodies in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Does the client have a diagnosis of growth hormone deficiency in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #5)

5. *Manual Step* - Does the client have low GH levels (evoked GH ≤ 7 ng/mL) in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

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STEP 2: COMPLETE REQUIRED CRITERIA

6. *Manual Step* - Does the client have a height standard deviation score ≤ -3.0 in the last 90 days?

☐ Yes (Go to #7) ☐ No (Deny)

7. *Manual Step* - Does the client have a basal IGF-1 standard deviation score ≤ -3.0 in the last 90 days?

☐ Yes (Go to #8) ☐ No (Deny)

8. *Manual Step* - Does the client have a diagnosis of an open epiphysis in the last 90 days?

☐ Yes (Go to #9) ☐ No (Deny)

9. Does the client have a diagnosis of chronic renal disease (CRD), pituitary tumors, hypothyroidism or chromosomal abnormalities in the last 730 days?

☐ Yes (Deny) ☐ No (Go to #10)

10. Does the client have a diagnosis of malignancy or malnutrition in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #11)

11. Does the client have a history of antineoplastics (specific for mecasermin) in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #12)

12. Does the client have a history of chemotherapy CPTs on file in the last 365 days?

☐ Yes (Deny) ☐ No (Go to #13)

13. Is the dose less than or equal to (≤) 0.24 mg/kg/day?

☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.