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 growth hormone (GH) levels (evoked GH less than or equal to [≤] 7 ng/mL) in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

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6. *Manual Step* - Does the client have a height standard deviation score less than or equal to (≤) -3.0 in the last 90 days?

   ☐ Yes (Go to #7) ☐ No (Deny)

7. *Manual Step* - Does the client have a basal Insulin-like growth factor 1 (IGF-1) standard deviation score less than or equal to (≤) -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?

    Examples include ALKERAN, anastrozole (ARIMIDEX), AROMASIN, AVODART, bicalutamide (CASODEX), CARAC, CEENU, COSMEGEN, cyclophosphamide, cytarabine, EFUDEX, EMCYT, etoposide, EVISTA, FARESTON, finasteride (PROSCAR), fluoroplex, fluorouracil, flutamide, GEMZAR, GLEEVEC, HEXALEN, HYCAMTIN, IRESSA, JALYN, letrozole (FEMARA), LEUKERAN, LYSODREN, KISQALI FEMARA, MATULANE, megestrol (MEGACE), mercaptopurine (PURINETHOL), methotrexate, mitomycin, mitoxantrone (NOVANTRONE), MYLERAN, NEXAVAR, NILANDRON, OFORTA, ONCASPAR, SPRYCEL, SUTENT, TABLOID, tamoxifen, TARCEVA, TARGRETIN, TASIGNA, TEMODAR, TYKERB, vinblastine, vincristine, VOTRIENT, XELODA, and ZOLINZA

    ☐ 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)

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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.