**Increlex (mecasermin)**  
**DRUG.00086**

### Override

<table>
<thead>
<tr>
<th>Medication</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increlex (mecasermin)</td>
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### Approval Criteria

**Increlex (mecasermin)** may be approved for the treatment of individuals greater than 2 years of age with the following indications:

**I.** Growth failure in children with severe primary IGF-1 deficiency, as defined by:
   - Height standard deviation (SD) score less than or equal to -3.0; **AND**
   - Basal IGF-1 SD score less than or equal to -3.0; **AND**
   - Normal or elevated growth hormone (GH) levels (greater than 10 ng/mL on standard GH stimulation tests, see Anthem® medical policy DRUG.00009 for additional information) are present;

**OR**

**II.** Growth hormone gene deletion with the development of neutralizing antibodies to GH.

Continuation of treatment with **Increlex (mecasermin)** may be approved when the following criteria have been met:

**I.** Growth velocity is greater than or equal to 2 cm total growth in 1 year; **AND**

**II.** Final adult height has not been reached.

**Increlex (mecasermin)** may not be approved for individuals with the following contraindications:

**I.** Closed epiphyses; **OR**

**II.** Suspected or known malignancies.

**Increlex (mecasermin)** may not be approved for the treatment of all other indications, including but not limited to:

**I.** When any of the approval criteria above are not present; **OR**

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.
Market Applicability/Effective Date

<table>
<thead>
<tr>
<th>Market</th>
<th>FL &amp; FHK</th>
<th>FL MMA</th>
<th>FL LTC</th>
<th>GA</th>
<th>KS</th>
<th>KY</th>
<th>LA</th>
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<th>NJ</th>
<th>NV</th>
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<tbody>
<tr>
<td>Applicable</td>
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</tbody>
</table>

*FHK- Florida Healthy Kids

II. Growth velocity is less than 2 cm total growth in 1 year; OR
III. Final adult height has been reached; OR
III. Secondary IGFD (for example, due to GH deficiency, untreated malnutrition, untreated hypothyroidism or other causes).

State Specific Mandates

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Key References:


This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

| Market | FL & FHK | FL MMA | FL LTC | GA | KS | KY | LA | MD | NJ | NV | NY | TN | TX | WA |
|--------|---------|--------|--------|----|----|----|----|----|----|----|----|----|----|----|----|
| Applicable | X | NA | NA | X | NA | X | X | X | X | X | X | NA | NA | X |

*FHK- Florida Healthy Kids
