

Reference number(s)
1740-A

SPECIALTY GUIDELINE MANAGEMENT

INCRELEX (mecasermin)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no contraindications or exclusions to the prescribed therapy.

FDA-Approved Indications

Increlex is indicated for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.

Severe primary IGF-1 deficiency is defined by:

- Height standard deviation (SD) score ≤ -3.0 and
- Basal IGF-1 SD score ≤ -3.0 and
- Normal or elevated GH.

Severe primary IGF-1 deficiency includes classical and other forms of GH insensitivity. Patients with primary IGF-1 deficiency may have mutations in the GH receptor (GHR), post-GHR signaling pathway including the IGF-1 gene. They are not GH deficient, and therefore, they cannot be 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.

Limitations of use: Increlex is not a substitute to GH for approved GH indications.

All other indications are considered experimental/investigational and not medically necessary.

II. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review for continuation of therapy requests:

- A. Total duration of treatment (approximate duration is acceptable)
- B. Date of last dose administered
- C. Approving health plan/pharmacy benefit manager
- D. Date of prior authorization/approval
- E. Prior authorization approval letter

III. CRITERIA FOR INITIAL APPROVAL

Severe Primary IGF-1 Deficiency

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Authorization of 12 months may be granted to members with severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:

- A. Pretreatment height is ≥ 3 standard deviations (SD) below the mean for age and gender
- B. Pretreatment basal IGF-1 level is ≥ 3 SD below the mean for age and gender
- C. Pediatric GH deficiency has been ruled out with a provocative GH test (i.e., peak GH level ≥ 10 ng/mL)
- D. Epiphyses are open

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for the continuation of therapy of severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:

- A. The member's growth rate is > 2 cm/year² or there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty).
- B. Epiphyses are open (confirmed by X-ray or X-ray is not available).

V. REFERENCES

1. Increlex [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; December 2019.
2. Caremark Clinical Programs Review. Focus on growth hormones, growth hormone releasing hormone, Increlex, Somavert. December 18, 2006.