BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

INCRELEX® (mecasermin) subcutaneous solution
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Medical Necessity Requirements for INCRELEX (mecasermin)

Criteria for Initial Therapy:

Prescriber Qualifications
- Prescribed by a physician specializing in the diagnosis or in consultation with an Endocrinologist

Indication
- Growth failure from severe primary insulin like growth factor 1 deficiency (IGFD) and **ALL** of the following:
  - Height is 3 standard deviations or more below normal for age and sex
  - Basal IGF 1 level is 3 standard deviations or more below normal for age and sex

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  - Normal or elevated growth hormone level
- Growth hormone gene deletion with development of neutralizing antibodies to growth hormone

Age Requirement
- 2 years to 17 years of age

Baseline Clinical Evaluation
- Funduscopic examination
- Preprandial glucose
- Documentation of open epiphyses on most recent bone radiograph
- No evidence of secondary forms of IGF deficiency (e.g., growth hormone deficiency, malnutrition, hypothyroidism, chronic systemic steroid use)
- Not used as a substitute for growth hormone for approved growth hormone indications

Brand Specific Criteria
- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

Safety
- No use in neonates or infants due to benzyl alcohol preservative
- No concurrent use with any growth hormone product
- No renal impairment or hepatic impairment
- No FDA label contraindications:
  - Malignant neoplasia
  - History of malignancy
  - Closed epiphyses

Documentation Requirements
- Completed request form including:
  - Chart notes
  - Lab results (IGF 1 level, growth hormone level, height measurements)
  - Supporting clinical documentation

Initial Therapy Criteria Approval Duration
- 12 months OR end of plan year

Criteria for Continuation of Therapy (renewal therapy):
Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy

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Prescriber Qualifications
- Continues to be seen by a physician specializing in the diagnosis or in consultation with an Endocrinologist

Clinical Response
- **ALL** of the following:
  - Height increased at least 2 cm total growth in one year over the previous year (submit previous and current year height values with dates)
  - Documentation that expected goal adult height has not been reached
  - Epiphyses remain open on most recent bone radiograph

Adherence
- Adherence to the prescribed therapy regimen has been documented

Brand Specific Criteria
- Have failure, contraindication or intolerance with **THREE** generic equivalents (if available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

Safety
- No new contraindications or significant adverse drug effects, including:
  - History of malignancy
  - Closed epiphyses
  - Evidence of benign or malignant neoplasm
  - Intracranial hypertension
  - Benzyl alcohol reaction (“gasping syndrome”)
- No use in neonates or infants due to benzyl alcohol preservative
- No concurrent use with any growth hormone product
- Not used as a substitute for growth hormone for approved growth hormone indications
- No renal impairment or hepatic impairment

Documentation Requirements
- Chart notes
- Supporting clinical documentation with evidence of improvement
- Lab values confirming safe use

Continuation Therapy Criteria Approval Duration
- 12 months OR end of plan year

ORIGINAL EFFECTIVE DATE: 12/01/2022 | ARCHIVE DATE: | LAST REVIEW DATE: 11/20/2025 | LAST CRITERIA REVISION DATE: 11/20/2025

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Criteria for Off-Label Use Requests:

Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. Off-Label Use of Non-Cancer Medications
2. Off-Label Use of Cancer Medications

Description:

Increlex (mecasermin) is an injectable solution of human insulin-like growth factor-1 (IGF-1) produced by recombinant DNA technology. Increlex is used for the treatment of growth failure in children with severe primary IGF-1 deficiency, also referred to as primary IGFD. Primary IGFD is a growth hormone (GH)-resistant state characterized by lack of IGF-1 production in the presence of normal or elevated levels of endogenous GH.

These children have normal or elevated levels of growth hormone but due a deficiency of IGF-1, are unable to utilize the growth hormone resulting in extremely short stature. Increlex is also used in children with a growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. It is not a substitute for GH for approved GH indications.
Severe Primary IGFD includes classical and other forms of growth hormone insensitivity. Patients with Primary IGFD may have mutations in the GH receptor (GHR), post-GHR signaling pathway including the IGF-1 gene. However, they are not GH deficient, and therefore, they are not 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. Increlex is not a substitute for GH treatment.

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Resources:

Increlex (mecasermin) product information, revised by manufacturer Eton Pharmaceuticals, Inc. 05-2025 Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Richmond Padilla EJ, Rogol AD. Growth hormone insensitivity syndromes. In: UpToDate, Geffner ME, Kremen J (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated July 09, 2025. Accessed September 28, 2025.

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