Pharmacy Policy Bulletin: J-0102 Increlex (mecasermin) – Commercial and Healthcare Reform	
Number: J-0102	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1.):** **1.** Miscellaneous Specialty Drugs Injectable = Yes w/ Prior Authorization **Healthcare Reform:** Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-0102-020	**Original Date:** 12/07/2005
Effective Date: 10/08/2025	**Review Date:** 09/17/2025

Drugs Product(s):	• Increlex (mecasermin)
FDA-Approved Indication(s):	• Treatment of growth failure in pediatric patients 2 years of age and older with: ○ Severe primary insulin-like growth factor-1 (IGF-1) deficiency or ○ Growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH

Background:	• Increlex is recombinant form of human insulin-like growth factor 1 (rHIGF-1) that mediates anabolic and growth-promoting effects of GH by activating Type 1 IGF-1 receptor. • GH binds to receptors stimulating the synthesis and secretion of IGF-1. In target tissues, the IGF-1 receptor is activated by IGF-1 leading to intracellular signaling which stimulates multiple processes resulting in statural growth. • Severe primary IGF-1 deficiency is defined by a height standard deviation score ≤ –3.0, a basal IGF-1 standard deviation score ≤ –3.0 and normal or elevated GH. • Serum IGF-1 reference ranges vary by age, sex, and pubertal status. The reference ranges for the laboratory performing the tests should be used to assess whether criteria are met. • Genetics can cause growth hormone deficiency (GHD) including deletions and mutation. The development of anti-GH antibodies neutralizes circulating GH and inhibits its growth promoting effect. • Prescribing Considerations: ○ Increlex is not a substitute to GH for approved GH indications. ○ Increlex is contraindicated in patients with closed epiphyses and malignant neoplasia. ○ There is no evidence to suggest combination therapy with growth hormone is appropriate or beneficial. ○ 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 steroid.

	○ The role of IGF-1 therapy in adults remains investigational.

Approval Criteria

I. Initial Authorization

A. Severe Primary IGF-1 Deficiency

When a benefit, coverage of Increlex may be approved when all of the following criteria are met **(1. through 5.)**:

1. The member has a diagnosis of primary IGF-1 deficiency (ICD-10 code: E34.321), classified as severe.
2. The member has a normal or elevated response (> 10 ng/ml) to two (2) of the following standard growth hormone stimulation tests **(a. through f.)**:
   - **a.** arginine
   - **b.** clonidine
   - **c.** glucagon
   - **d.** insulin
   - **e.** levodopa
   - **f.** propranolol
3. The member has serum IGF-1 concentration that is less than or equal to three (3) standard deviations below the normal value based on laboratory reference range.
4. The member's height is less than or equal to three (3) standard deviations below normal (at or below the third percentile for gender and age).
5. The member meets one (1) of the following **(a. or b.)**:
   - **a.** If female, bone age ≤ 14 years
   - **b.** If male, bone age ≤ 16 years

B. Growth Hormone Gene Deletion

When a benefit, coverage of Increlex may be approved when all of the following criteria are met **(1. through 5.)**:

1. The member has a diagnosis of growth hormone deficiency caused by gene deletion (no ICD-10 code).
2. The member meets one (1) of the following criteria **(a. or b.)**:
   - **a.** Clinical documentation (i.e., growth charts) indicating a growth velocity at least 2 standard deviations below the age-appropriate mean.
   - **b.** Clinical documentation (i.e., growth charts) indicating a height at least 2.25 standard deviations below the age-appropriate mean.
3. The member has a subnormal response (< 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests **(a. through f.)**:
   - **a.** arginine
   - **b.** clonidine
   - **c.** glucagon
   - **d.** insulin
   - **e.** levodopa
   - **f.** propranolol
4. The member has developed neutralizing antibodies to growth hormone product(s).
5. The member meets one (1) of the following **(a. or b.)**:
   - **a.** If female, bone age ≤ 14 years
   - **b.** If male, bone age ≤ 16 years

II. Reauthorization

When a benefit, reauthorization of Increlex may be approved when all of the following criteria are met **(A. and B.)**:

A. There is clinical documentation (i.e., growth charts) indicating a growth velocity of at least 2 cm/year.

B. The member meets one (1) of the following criteria **(1., 2., or 3.)**:
   1. The member is a male with a chronological age > 16 years and a bone age ≤ 16 years.
   2. The member is a female with a chronological age > 14 and a bone age ≤ 14 years.
   3. The member meets one (1) of the following criteria **(a. or b.)**:
      a. The member is a male with a chronological age ≤ 16 years
      b. The member is a female with a chronological age ≤ 14 years

Limitations of Coverage

I. Use of Increlex in combination with growth hormone will not be covered.
II. Coverage of drug(s) addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.
III. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

Automatic Approval Criteria

None

References:

1. Increlex [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; July 2025.
2. Grimberg A, DiVall SA, Polychronakos C, et al. Guidelines for Growth Hormone and Insulin-Like Growth Factor-I Treatment in Children and Adolescents: Growth Hormone Deficiency, Idiopathic Short Stature, and Primary Insulin-Like Growth Factor-I Deficiency. *Horm Res Paediatr*. 2016;86(6):361-397.
3. Larsen, P. R., & Williams, R. H. (2003). *Williams Textbook of Endocrinology*. Philadelphia: Saunders.
4. DRUGDEX System (Micromedex 2.0). Greenwood Village, CO: Truven Health Analytics; 2024.
5. Parker KL, Schimmer BP. Introduction to endocrinology: the hypothalamic-pituitary axis. In: Brunton LL, Chabner BA, Knollmann BC. editors. Goodman & Gilman's: The pharmacological basis of therapeutics, 12e. New York, NY: McGraw-Hill; 2011. Accessed September 14, 2020.
6. Insulin-Like Growth Factor 1 (IGF1), LC-MS and Insulin-Like Growth Factor-Binding Protein 3 (IGFBP3) Growth Panel. Mayo Clinic. 2017. Accessed July 28, 2025.