Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health

Mecasermin (Increlex) – Medical Necessity Request

Complete page 1 for Initial Requests Only*

General Information

- Current Weight: _____ lbs or _____kg
- Is the medication prescribed by or in consultation with an Endocrinologist?
  Yes or No

Contraindication Information

Does member have any of the following:

- Pediatric member with malignant neoplasia or a history of malignancy?
  Yes or No
- Closed epiphyses?
  Yes or No

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

□ **Growth hormone (GH) gene deletion**

1. Has the member developed neutralizing antibodies to growth hormones (GH)? **Yes or No**

□ **Severe primary IGF-1 deficiency (Primary IGFD)**

1. Does the member have a height standard deviation score ≤ -3.0? **Yes or No**
2. Does the member have basal IGF-1 standard deviation score ≤ -3.0 **Yes or No**
3. Does the member have normal or elevated growth hormone (GH) **Yes or No**

□ **Other (please specify):** _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Mecasermin (Increlex) – Medical Necessity Request

Complete page 2 only for Subsequent/Renewal requests*

General Information
• Current Weight: _____ lbs or _____ kg

Diagnosis Information (please select diagnosis):

□ **Growth hormone (GH) gene deletion**

□ **Severe primary IGF-1 deficiency (Primary IGFD)**

□ **Other (please specify):** _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**