



**Increlex – mecasermin (rDNA ORIGIN)**  
**Iplex – mecasermin rinfabate (rDNA ORIGIN)**

**Member Information**

Name \_\_\_\_\_  
Enrollment / Cardholder ID \_\_\_\_\_  
Group / Plan \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_

**Relationship (Circle)**

**Subscriber**      **Spouse**      **Dependent**  
**Gender (Circle)**  
**Male**                      **Female**  
**AGE:** \_\_\_\_\_

**Practitioner Information**

Name \_\_\_\_\_  
Agent / Contact Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
Office / Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
City State Zip \_\_\_\_\_  
Phone (       )       - \_\_\_\_\_  
Fax (       )       - \_\_\_\_\_  
Email \_\_\_\_\_ @ \_\_\_\_\_

**Primary Diagnosis Condition /  
Diagnosis Related – Reason for Request**

- Growth failure with severe primary insulin-like growth factor (IGF-1) deficiency  
Growth failure with Growth hormone (GH) deletion and the patient has developed neutralizing antibodies to GH. Please provide the following:
- o Height standard deviation score for age and sex: \_\_\_\_\_
  - o Basal insulin-like growth factor-1 (IGF-1) standard deviation score for age and sex: \_\_\_\_\_
  - o Stimulated serum Growth hormone (GH) levels (peak level) defined in nanograms per milliliter (ng/ml): \_\_\_\_\_  
or
  - o Unstimulated Basal serum GH level (ng/ml): \_\_\_\_\_

**Strength / Dose**

**Duration of Therapy (Expected)**

**Formulary Alternatives  
Attempted/Outcome**

**Clinical Drug / Lab History Pertinent to Request**

**Contact Pharmacy?                      Y                      N**  
**Pharmacy Phone Number**

**Practitioner Signature**

Date Received: \_\_\_\_\_  
Reviewed By: \_\_\_\_\_  
Forwarded To: \_\_\_\_\_

**FAX Form to  
877-800-5633**