

PRIOR AUTHORIZATION POLICY

POLICY: Growth Disorders – Increlex Prior Authorization Policy

- Increlex[®] (mecasermin [rDNA origin] subcutaneous injection – Ipsen)

REVIEW DATE: 11/30/2022

OVERVIEW

Increlex, an insulin-like growth factor (IGF-1), is indicated for the treatment of growth failure in pediatric patients ≥ 2 years of age with the following conditions:¹

- **Primary IGF-1 deficiency**, for patients with severe disease, defined as:
 - Height standard deviation score ≤ -3.0 ; AND
 - Basal IGF-1 standard deviation score ≤ -3.0 ; AND
 - Normal or elevated growth hormone level.
- **Growth hormone gene deletion**, in patients who have developed neutralizing antibodies to growth hormone.

Increlex is given by subcutaneous injection twice daily, shortly before or after a meal or snack. Treatment with Increlex should continue until the epiphyses fuse indicating full growth potential has been achieved.² It is a limitation of use that Increlex is not a substitute to growth hormone for approved growth hormone indications. Increlex is not indicated in secondary forms of IGF-1 deficiency, such as growth hormone deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory corticosteroids.¹

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Increlex. Because of the specialized skills required for evaluation and diagnosis of patients treated with Increlex as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Increlex to be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Increlex is recommended in those who meet one of the following criteria:

FDA-Approved Indications

1. **Insulin-Like Growth Factor-1 (IGF-1) Deficiency – Severe, Primary Disease.** Approve for 1 year if the patient meets ONE of the following conditions (A or B):
 - A) Initial Therapy or Patient Has Been on Increlex < 1 Year. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):
 - i. Patient is ≥ 2 years of age; AND
 - ii. The epiphyses are open; AND
 - iii. Height standard deviation score is ≤ -3.0 at baseline; AND
 - iv. Basal IGF-1 standard deviation score is ≤ -3.0 at baseline; AND

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Note: Baseline is prior to initiation of treatment with Increlex. Reference ranges for IGF-1 vary among laboratories and are dependent upon age, gender, and puberty status.

- v. Growth hormone concentration is normal or increased at baseline; AND
 - vi. Patient will not be receiving concurrent treatment with growth hormone; AND
 - vii. The medication is prescribed by or in consultation with a pediatric endocrinologist.
- B) Patient Has Been Receiving Increlex for ≥ 1 Year.** Approve if the patient meets ALL of the following (i, ii, and iii):
- i. Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - ii. The epiphyses are open; AND
 - iii. Patient will not be receiving concurrent treatment with growth hormone.
- 2. Growth Hormone Gene Deletion.** Approve for 1 year if the patient meets ONE of the following conditions (A or B):
- A) Initial Therapy or Patient Has Been on Increlex < 1 Year.** Approve if the patient meets ALL of the following (i, ii, iii, iv, and v):
- i. Patient is ≥ 2 years of age; AND
 - ii. The epiphyses are open; AND
 - iii. Patient has developed neutralizing antibodies to growth hormone; AND
 - iv. Patient will not be receiving concurrent treatment with growth hormone; AND
 - v. The medication is prescribed by or in consultation with a pediatric endocrinologist.
- B) Patient Has Been Receiving Increlex for ≥ 1 Year.** Approve if the patient meets ALL of the following (i, ii, iii, and iv):
- i. Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - ii. The epiphyses are open; AND
 - iii. Patient has developed neutralizing antibodies to growth hormone; AND
 - iv. Patient will not be receiving concurrent treatment with growth hormone.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Increlex is not recommended in the following situations:

- 1. Idiopathic Short Stature, Growth Hormone Deficiency.** A Phase II open-label study evaluated somatropin in combination with Increlex in children with short stature associated with IGF-1 deficiency.³ This study included prepubertal children with IGF-1 standard deviation score of ≤ -1 for age and gender, height standard deviation score ≤ -2 for age and gender, and growth hormone sufficiency demonstrated by a maximal stimulated growth hormone response of ≥ 10 ng/mL. This study was prematurely terminated at 3 years (compared to the planned 6 years) for “strategic reasons.”⁴ Somatropin monotherapy is indicated for idiopathic short stature.
- 2.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Increlex[®] subcutaneous injection [prescribing information]. Cambridge, MA: Ipsen; December 2019.
2. Cohen J, Blethen S, Kuntze J, et al. Managing the child with severe primary insulin-like growth factor-1 deficiency (IGFD): IGFD diagnosis and management. *Drugs R D*. 2014;14(1):25-29.
3. Rosenbloom AL. Is there a role for recombinant insulin-like growth factor-I in the treatment of idiopathic short stature? *Lancet*. 2006;368:612-616.
4. Ipsen. rhGH and rhIGF-1 combination therapy in children with short stature associated with IGF-1 deficiency. In: ClinicalTrials.gov. Bethesda (MD): National Library of Medicine (US). Available at: [rhGH and rhIGF-1 Combination](#)

[Therapy in Children With Short Stature Associated With IGF-1 Deficiency - Full Text View - ClinicalTrials.gov.](#)
NCT00572156. Accessed on November 28, 2022.