ATRIO HEALTH PLANS

Growth Hormone Antagonist
Increlex (mecasermin) J2170, Signifor LAR (pasireotide) J2502
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ **Increlex**

- ☐ Child with growth failure associated with severe primary IGF-1 deficiency, as defined by:
  - ☐ Height standard deviation (SD) score less than or equal to –3.0; AND
  - ☐ Basal IGF-1 SD score less than or equal to –3.0; AND
  - ☐ Normal or elevated growth hormone (GH) levels (greater than 10 ng/ml on standard GH stimulation tests) are present;

OR ☐ Individual with growth hormone gene deletion with the development of neutralizing antibodies to GH.

☐ **Signifor**

- ☐ Diagnosis of acromegaly; AND
  - ☐ Diagnosis of acromegaly has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: Insulin-like Growth Factor 1 levels; Oral Glucose Tolerance Test with associated Growth Hormone (GH) levels) that are indicative of a positive test; AND

☐ Individual has had an inadequate response to surgery and/or surgery is not an option (including but not limited to, individual is an inappropriate candidate for surgical-based therapy).

OR ☐ diagnosis of Cushing's disease; AND

☐ Diagnosis of Cushing's has been verified by, or in consultation with, a board-certified endocrinologist who has reviewed and verified the test results (including but not limited to: 24-hour urinary free cortisol (UFC) test; Dexamethasone suppression test (DST); Late-night salivary cortisol (LNSC) test) that are indicative of a positive test; AND

☐ One of the following:

☐ Disease persists or recurs following pituitary surgery; OR

☐ Pituitary surgery is not indicated or an option.

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ Increlex only

☐ Documentation is provided that growth velocity is greater than or equal to 2 cm total growth in 1 year; AND

☐ Documentation is provided that final adult height has not been reached.

☐ Signifor

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Growth Hormone Antagonists PA

Drug Name(s):

SIGNIFOR LAR	**PASIREOTIDE**
INCRELEX	**MECASERMIN**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approvals will be for 12 months

FDA Indications:

Increlex

- Growth delay due to insulin-like growth factor type 1 deficiency (Severe)

Signifor

- Acromegaly, In patients with an inadequate response to surgery or who are not candidates for surgery
- Cushing's syndrome, When pituitary surgery is not an option or has not been curative

Off-Label Uses:

Signifor

- Carcinoid syndrome, Inadequately controlled with first generation somatostatin analogs - Neuroendocrine tumor, Metastatic, of the digestive tract

Age Restrictions:

Safety and effectiveness of ocrelizumab have not been established in pediatric patients

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/AD5F4D/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/441433/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Pasireotide&fromInterSaltBase=true&UserMdxSearchTerm=%24userMdxSearchTerm&false=null&=null#

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