I. Requirements for Prior Authorization of Growth Factors

A. Prescriptions That Require Prior Authorization

Prescriptions for Growth Factors that meet the following conditions must be prior authorized.

1. A prescription for a preferred or non-preferred Growth Factor. See Preferred Drug List (PDL) for the list of preferred Growth Factors at: www.providersynergies.com/services/documents/PAM_PDL.pdf

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Growth Factor, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For a non-preferred Growth Factor, whether the recipient has a documented history of therapeutic failure, contraindication or intolerance to the preferred Growth Factors

2. For mecasermin (Increlex), whether the recipient:

   a. Has growth hormone gene deletion and developed neutralizing antibodies to growth hormone **OR**

   b. Has a diagnosis of severe primary insulin-like growth factor-1 deficiency (IGFD) with growth failure documented by the following:

      i. A height standard deviation score less than or equal to -3.0

      AND

      ii. A basal IGF-1 standard deviation score less than or equal to -3.0

      AND

      iii. A normal or elevated growth hormone

AND

c. Has epiphyses that are confirmed as open for the following recipients:

i. Males and females in Tanner stage greater than or equal to 3 **OR**

ii. Females 12 years of age and older **OR**

iii. Males 14 years of age and older

AND

d. Is prescribed mecasermin (Increlex) by a specialist such as an endocrinologist

3. For Renewals of prescription of mecasermin (Increlex): Whether the recipient:

a. Demonstrates a growth response equal to or greater than 4.5 cm/yr (pre-pubertal growth rate) or equal to or greater than 2.5 cm/yr (post-pubertal growth rate)

AND

b. Has not reached their expected final adult height (defined as mid-parenteral height)

AND

c. Has epiphyses that are confirmed as open for the following recipients:

i. Males and females in Tanner stage greater than or equal to 3 **OR**

ii. Females 12 years of age and older **OR**

iii. Males 14 years of age and older

D. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the

medical necessity of the request for a prescription for a Growth Factor. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.