



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Increlex

Page: 1 of 2

Effective Date: 8/17/2023

Last Review Date: 6/2/2023

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input checked="" type="checkbox"/> Virginia	<input type="checkbox"/> Arizona

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Increlex under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no contraindications or exclusions to the prescribed therapy.

FDA-Approved Indications

Increlex is indicated for the treatment of growth failure in pediatric patients 2 years of age and older with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.

Severe primary IGF-1 deficiency is defined by:

- Height standard deviation (SD) score ≤ -3.0 and
- Basal IGF-1 SD score ≤ -3.0 and
- Normal or elevated GH.

Limitations of use: Increlex is not a substitute to GH for approved GH indications. Increlex is not indicated for use in patients with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory corticosteroids.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Increlex

Policy/Guideline:

Documentation:

Submission of the following information is necessary to initiate the prior authorization review for continuation of therapy requests:

- A. Total duration of treatment (approximate duration is acceptable)
- B. Date of last dose administered



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- C. Approving health plan/pharmacy benefit manager
- D. Date of prior authorization/approval
- E. Prior authorization approval letter

Criteria for Initial Approval:
Severe Primary IGF-1 Deficiency

Authorization of 12 months may be granted to members with severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:

- A. Pretreatment height is ≥ 3 standard deviations (SD) below the mean for age and gender
- B. Pretreatment basal IGF-1 level is ≥ 3 SD below the mean for age and gender
- C. Pediatric GH deficiency has been ruled out with a provocative GH test (i.e., peak GH level ≥ 10 ng/mL)
- D. Epiphyses are open

Continuation of Therapy:

Authorization of 12 months may be granted for continuation of therapy for severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH when ALL of the following criteria are met:

- A. The member's growth rate is > 2 cm/year or there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty).
- B. Epiphyses are open (confirmed by X-ray or X-ray is not available).

Approval Duration and Quantity Restrictions:

Approval: 12 months

References:

1. Increlex [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; December 2019.