increlex® (mecasermin) injection 10 mg

Patient Referral Form

Fax: 855-813-2039
Phone: 833-343-2500

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Increlex®**

Patient Information *Please Print

Last Name: First Name:		SSN:	Sex: ◯ M ◯ F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	Preferred method of Contact: ◯ Day # ◯ Evening # ◯ Cell #
DOB:	Weight Lbs:	Kg: Height:	BSA:
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:			
NPI: DEA:		Medicaid UPIN:	State License #:
Address:	City:		State: Zip:
Name of office Contact Person:		Office Contact Person Email:	
Office Contact Person Phone:		Office Contact Person Fax:	
PA Office Contact Name:		PA Office Contact Number:	

Prescription

Increlex® (mecasermin) injection 40mg/4mL

SIG: Has the patient previously been on Increlex therapy? Yes ☐ No ☐ If yes, last administered dose: _____ mg/kg on _____ (MM/DD/YYYY)

ONLY COMPLETE FOR NEWLY DIAGNOSED PATIENTS

Please select an initial dose	☐ 0.04 mg/kg ☐ 0.05 mg/kg ☐ 0.06 mg/kg ☐ 0.07 mg/kg ☐ 0.08 mg/kg	_____ kg weight X _____ Dose = _____ mg X 10 = Inject _____ Units BID
☐ Step Up	⬇ ⬇ ⬇ ⬇ ⬇	
If well tolerated after 7 days	☐ 0.08 mg/kg ☐ 0.09 mg/kg ☐ 0.10 mg/kg ☐ 0.11 mg/kg ☐ 0.12 mg/kg	_____ kg weight X _____ Dose = _____ mg X 10 = Inject _____ Units BID
☐ Step Up	⬇	
If well tolerated after an additional 7 days, maintain this dose.	**Maximum recommended dose of 0.12 mg/kg BID*** ☐ **0.12 mg/kg BID***	_____ kg weight X _____ Dose = _____ mg X 10 = Inject _____ Units BID

You may include different dosing schedule using your office prescription form.

Quantity_____Number of Refills_____ ☐ Dispense as Written

*Dosing over 0.12 mg/kg BID has not been evaluated, and due to potential hypoglycemic effects, patients should not be dosed over 0.12 mg/kg BID.

Medical Necessity

Please check applicable ICD-10 code: Therapy Start Date: _____

☐ Primary insulin- like growth factor -1 (E34.321) ☐ Other:

Allergies: _____ ☐ NKDA

I certify I am prescribing Increlex® for this patient for a medically necessary purpose.

Dispense as Written: _____ **Date Written:** _____
(Stamped Signatures Are Not Valid)

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

This Prescription Form is only valid if FAXED to Anovo @855-813-2039

Form: Increlex.Rx.01
Effective Date: 07.02.25
Revision Date:
1734-v3