increlex® (mecasermin) injection 10 mg

Patient Referral Form

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

anovo SPECIALTY PHARMACY

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:		Phone #	
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 Phone:	

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	_____ X _____ mg/kg = _____ mg X 10 kg weight Dose = Inject _____ BID Units
☐ 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	_____ X _____ mg/kg = _____ mg X 10 kg weight Dose = Inject _____ BID Units
☐ 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*	_____ X _____ mg/kg = _____ mg X 10 kg weight Dose = Inject _____ BID Units

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.

I certify that I have prescribed Increlex as described above for this patient, based on my professional judgement for a medically necessary purpose. I authorize the release of medical and/or other patient information relating to Increlex to agents of Eton Pharmaceuticals, Inc. and service providers (including, but not limited to pharmacies dispensing Increlex) to use and disclose as necessary for purposes including prior authorization, processing, and fulfillment of the prescription. I authorize CloudTop Health to prepare and submit prior authorization requests, appeal requests, and other related processing and administrative tasks on behalf of the prescriber and to receive notices in connection with requests which may include but is not limited to faxes, phone calls, mail, email, or any other form of communication. I authorize that this form (and the information included herein) may be provided to AnovoRx.

I certify I am prescribing Increlex® for this patient for a medically necessary purpose. **Date Written:** _____

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

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

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Patient Information

Last Name:	First Name:	Sex: ☐ M ☐ F

Medical Necessity

Primary diagnosis:	Date of Diagnosis:	Patient Age at Diagnosis:

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

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

☐ Other _____

Allergies: _____ ☐ NKDA

Confidentiality Statement

This message is intended only for the individual or entity to which it is addressed. It may contain information which is proprietary and confidential. It may also contain privileged, confidential information that is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 833-343-2500 to obtain instructions as to the proper destruction of the transmitted material.

Authorization and Release of Health Information

By signing this Authorization, I authorize each of my physicians, pharmacies, other healthcare providers, and each of my health insurers to use and disclose health information related to my medical conditions and my use of Increlex that identifies me personally, including my name, address, and telephone number(s) and information about my insurance, prescriptions, medical condition and health (my "Personal Information"), to Eton Pharmaceuticals, Inc., the manufacturer of Increlex), its Eton Cares Patient Support Program, and their respective agents, contractors, and third-party vendors, including providers of alternate sources of funding for prescription drug costs (collectively, "the Program") so that the Program may: (1) help to verify, assist with, and coordinate insurance coverage or otherwise obtain payment for my treatment; (2) coordinate my receipt of, and payment for Increlex; (3) conduct analytics to gain insight into and support the effectiveness of the Program; and (4) provide me with adherence reminders and support for Increlex, including via email, text or other means of communication. I understand that once my Personal Information has been disclosed to the Program, state and federal privacy laws may no longer protect the Information and that it may be subject to further disclosure by the Program. I also understand that the Program intends to use and/or disclose my Personal Information only for the purposes described in this Authorization and that any results of the analytics will only be shared outside of the Program after being anonymized. I understand that my pharmacy, health insurance company, and healthcare providers may receive payment from Eton Pharmaceuticals, Inc. in exchange for disclosing my Personal Information to the Program and/or for providing me with support services. I understand that I do not have to sign this Authorization and that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be affected if I do not sign it. I also understand, however, that if I do not sign this Authorization, the Program cannot provide me with assistance. This Authorization will remain in effect for five (5) years, unless I cancel my enrollment before then. I understand that I may revoke (cancel) this Authorization at any time by sending written notice to the Program at the address listed below. Upon receipt of my revocation, the Program will stop using and disclosing my Personal Information for the purposes described in this Authorization, except to the extent that the Program or others have already taken action in reliance on this Authorization. I understand that my revocation will not apply to information that has already been used or disclosed prior to the Program's receipt of my revocation, and will not affect my ability to receive treatment, although the Program may no longer be able to provide assistance to me after revocation. I understand that I am entitled to a copy of this Authorization after signing on the previous page.

Form: Increlex.Rx.01
Effective Date: 7.2.25
Revision Date: 07.24.25; 2.1.26
1734-v5

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Prescriber Information

Prescriber Name / Title:		NPI:	
Address:	City:	State:	Zip:

Patient Information

First Name:	Last Name:	DOB:	
Address:	City:	State:	Zip:

Prior Authorization Request

The patient's insurance requires prior authorization for this prescription. If you would like us to submit and follow up on the request, send a copy of the medication form, chart notes, labs and radiology reports along with this form.

Clinical Information

What is the patient's diagnosis?

☐ Severe primary IGF1 deficiency ☐ Growth hormone gene deletion ☐ Other

Has the patient's candidacy for the medication been confirmed according to the drug's package insert?

☐ Reviewed all contraindications and warnings (e.g. suspected neoplasia).

☐ Completed all necessary labs and monitoring (e.g. pre-prandial glucose monitoring).

Does the patient have severe deficiency defined by one of the following:

☐ Height standard deviation score ≤ -3, Basal IGF-1 standard deviation score ≤ -3, normal or elevated growth hormone

☐ Genetic confirmation

In the prescriber's opinion, would alternatives not be effective?

☐ The alternatives would not be as effective for treating the patient's condition.

☐ The alternatives would likely have adverse effects.

☐ Stable on current medication and changing to an alternative would likely cause adverse effects.

Notes:

All information is true and accurate to the best of my knowledge.

Authorized Signature: _____ **Title:** _____

Please sign to validate.