

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

Patient Information <i>*Please Print</i>	Last Name:		First Name:		SSN:		Sex: M F	
	Address:				City:		State:	
	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 #:	
	Prescription Card Name:		Phone #:	
	Policy #:		Group #:	
	Secondary Insurance Co. Name:		Phone #:	
	Policy Holder Name:		Policy #:	

Physician Information	Prescriber Name/Title:	
	NPI:	DEA:
	Medicaid UPIN:	
	State License #:	
	Address:	
	City:	
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. Day Supply _____ 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: _____
(Stamped Signatures Are Not Valid)

Date Written: _____

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

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