



Missouri Pharmacy Program – Preferred Drug List



Growth Hormones

Effective 12/05/2007

Revised 07/02/2010

Preferred Agents

Available with Clinical Edits

- Nutropin®
- Nutropin AQ Vial®
- Nutropin AQ Cartridge®
- Norditropin Nordiflex®
- Norditropin Cartridge®
- Genotropin Cartridge®
- Genotropin Pen®
- Saizen Vial®
- Tev-Tropin®

Non-Preferred Agents

Available with Clinical Edits

- Humatrope Cartridge®
- Humatrope Vial®
- Serostim®
- Zorbtive®
- **Omnitrope®**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
<ul style="list-style-type: none"> • Diagnosis of HIV with cachexia in the last 2 years. <ul style="list-style-type: none"> • Documented baseline body weight • Approval x 2 weeks • At 2 week follow up, no documented weight loss from baseline • Approval x 10 weeks • At 10 week follow up, patient's weight stable • Approval in 12 week increments <p>Documented compliance on current therapy regimen</p>	<p>Absence of approval criteria</p>
<ul style="list-style-type: none"> • For patients > 18 years of age: <ul style="list-style-type: none"> • Renal impairment, or chronic renal disease in last 2 years • History of growth hormone deficiency in last 2 years documented by one 	<p>Evidence of tumor activity or active neoplasm or current chemotherapy</p>

<p style="text-align: center;">of the following:</p> <ul style="list-style-type: none"> ▪ Insulin Tolerance Test (ITT) ▪ GH Stimulation Panel (with arginine, glucagons, propranolol, or levodopa) ▪ Serum IGF-I concentration (if ITT contraindicated) ▪ Equivalent Diagnostic Test (subject to clinical review) <ul style="list-style-type: none"> • History of any of the following in the last 2 years: (subject to clinical review) ▪ Prader-Willi Syndrome ▪ Turner Syndrome ▪ Crohns Disease ▪ Cardiomyopathy ▪ Short Bowel Syndrome 	
<ul style="list-style-type: none"> • Other Medically Accepted Uses <ul style="list-style-type: none"> • Idiopathic Short Stature • Short Stature Homeobox Gene 	Lack of therapeutic response at any given interval
<ul style="list-style-type: none"> • Follow up after 1 year may require repeat GH deficiency test within the most recent 6 months – (may be subject to Clinical Consultant Review) 	Lack of performance of diagnostic testing
<p>Failure to achieve desired therapeutic outcomes with trial on 2 or more preferred agents</p> <ul style="list-style-type: none"> • Documented trial period for preferred agents • Documented ADE/ADR to preferred agents 	
Documented compliance on current therapy regimen	Drug Prior Authorization Hotline: (800) 392-8030