Growth Hormones

*Effective 12/05/2007*
Revised 10/06/2016

**Preferred Agents**
- Egrifta®
- Genotropin Cartridge®
- Genotropin Pen/Syringe®
- Increlex®
- Norditropin Pen®
- Nutropin AQ Vial®
- Nutropin AQ Pen Cartridge®
- Nutropin AQ Nuspin®

**Non-Preferred Agents**
- Humatrope Cartridge®
- Humatrope Vial®
- Omnitrope®
- Saizen Cartridge®
- Saizen Vial®
- Serostim®
- Zomacton®
- Zorbtive®

**Approval Criteria**

- Diagnosis of HIV with cachexia in the last 2 years.
  - 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
- For patients > 18 years of age:
  - Renal Impairment, or chronic renal disease in last 2 years
  - History of growth hormone deficiency in last 2 years by one of the following:
    - 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)
  - History of any of the following in the last 2 years: (subject to clinical review)
    - Prader – Willi Syndrome
    - Crohns Disease
    - Cardiomyopathy
    - Short Bowel Syndrome
- Other Medically Accepted Uses (subject to Clinical Consultant Review)
  - Idiopathic Short Stature
  - Short Stature Homeobox Gene
- Follow up after 1 year may require repeat GH deficiency test within the most recent 6 months – (may be subject to clinical Consultant Review)
- Egrifta
  - Appropriate diagnosis of excess abdominal fat in HIV – infected patients with lipodystrophy
  - Currently complaint with antiretroviral medications (90 out of 120 days)
- Increlex
  - Appropriate diagnosis of growth failure in children with severe primary IGF–1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
  - Failure to achieve desired therapeutic outcomes with trail on 2 or more preferred agents
    - Documented trial period for preferred agents
    - Documented ADE/ADR to preferred agents
  - Documented compliance on current therapy regimen

**Denial Criteria**

- Absence of approval criteria
- Evidence of tumor activity or active neoplasm or current chemotherapy
- Lack of therapeutic response at any given interval
- Lack of performance of diagnostic testing
- Increlex
  - Patients with secondary forms of IGF-1 Deficiency
    - Growth Hormone deficiency
    - Malnutrition
    - Hypothyroidism
    - Chronic Treatment with pharmacologic doses of anti-inflammatory steroids
- Drug Prior Authorization Hotline: (800) 392-8030