

GROWTH HORMONE (Adult therapy)Genotropin, Humatrope, **Norditropin**, Omnitrope, Saizen, Sogroya, Zomacton

Preferred product: Norditropin

Pre - PA Allowance

None

Prior-Approval Requirements**Age** 18 years of age or older*

*Patients with open epiphyses must meet Growth Hormone Pediatric criteria

DiagnosesPatient must have **ONE** of the following:

1. Burn wounds (used for promotion of wound healing in burn patients)
2. Growth hormone deficiency due to at least **ONE** of the following:
 - a. Hypothalamic disease
 - b. Pituitary disease
 - c. Radiation therapy
 - d. Surgery
 - e. Trauma
 - f. Idiopathic childhood-onset or adult-onset growth hormone deficiency

AND the following:Documentation of GH stimulation test result from **ONE** of the following:

- a. Insulin tolerance test peak GH ≤ 5 ng/ml
- b. Glucagon, peak GH ≤ 3 ng/ml
- c. Arginine/L-Dopa, peak GH ≤ 1.5 ng/ml
- d. Arginine, peak GH ≤ 0.4 ng/ml

3. Documented IGF-1 level below the age and sex appropriate reference range **AND** panhypopituitarism (defined as a deficiency of three or more pituitary hormones such as gonadotropin [LH and/or FSH], adrenocorticotrophic hormone [ACTH], thyroid-stimulation hormone [TSH], arginine vasopressin [AVP])

AND ALL of the following:

1. Confirmation that GH is not being used for cosmetic, anti-aging or athletic performance enhancement

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2. Not being used in combination with another somatropin agent (such as Serostim, Zorbtive or any other GH)
3. **Non-preferred medications only:** Patient **MUST** have tried the preferred product (Norditropin) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

All requests are subject to approval by a secondary review by a clinical specialist for final coverage determination

Prior - Approval Limits**Duration** 12 months

Prior – Approval *Renewal* Requirements**Age** 18 years of age or older*

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 - c. Radiation therapy
 - d. Surgery
 - e. Trauma
 - f. Idiopathic childhood-onset or adult-onset growth hormone deficiency
 - g. Panhypopituitarism

AND ALL of the following:

1. Confirmation that GH is not being used for cosmetic, anti-aging or athletic performance enhancement
2. Not being used in combination with another somatropin agent (such as Serostim, Zorbtive or any other GH)
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**BlueCross
BlueShield**

Federal Employee Program.

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