

This policy applies to the following:

	Standard Control (SF)		Managed Medicaid Template (MMT)	✓	ACSF Chart (ACSFC)		Medical Benefit		Medicare Part B	Reference #
✓	Preferred Drug Plan Design (PDPD)		Marketplace (MF)		SF Chart (SFC)		Medical Benefit: Biosimilars First		Medicare Part B: Biosimilars First	4963-D
✓	Advanced Control Specialty (ACSF)		New to Market (NTM)	✓	VF Chart (VFC)		Medical Benefit: Add-on		Medicare Part B: Advanced Biosimilars First	
✓	Value (VF)		Aetna Health Exchange (AHE)				Medical Benefit: Managed Medicaid		Medicare Part B: Add-on	
			IVL							

EXCEPTIONS CRITERIA GROWTH HORMONE

PREFERRED PRODUCTS: GENOTROPIN AND NORDITROPIN

POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the growth hormone products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product. Zorbtive and Serostim are excluded from the program.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Growth hormone products

	Product(s)
Preferred*	<ul style="list-style-type: none"> • Genotropin (somatropin) • Norditropin (somatropin)
Targeted	<ul style="list-style-type: none"> • Humatrope (somatropin) • Nutropin AQ (somatropin) • Omnitrope (somatropin) • Saizen (somatropin) • Skytrofa (lonapegsomatropin-tcgd) • Sogroya (somapacitan-beco) • Zomacton (somatropin)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for a targeted product is provided when any of the following criteria is met:

A. Nutropin AQ is being prescribed for a patient with chronic kidney disease.

This policy applies to the following:

	Standard Control (SF)		Managed Medicaid Template (MMT)	✓	ACSF Chart (ACSFC)		Medical Benefit		Medicare Part B	Reference #
✓	Preferred Drug Plan Design (PDPD)		Marketplace (MF)		SF Chart (SFC)		Medical Benefit: Biosimilars First		Medicare Part B: Biosimilars First	4963-D
✓	Advanced Control Specialty (ACSF)		New to Market (NTM)	✓	VF Chart (VFC)		Medical Benefit: Add-on		Medicare Part B: Advanced Biosimilars First	
✓	Value (VF)		Aetna Health Exchange (AHE)				Medical Benefit: Managed Medicaid		Medicare Part B: Add-on	
			IVL							

- B. Humatrope or Zomacton is being prescribed for a patient with short stature homeobox-containing gene (SHOX) deficiency.

REFERENCES

1. Norditropin [package insert]. Plainsboro, NJ: Novo Nordisk, Inc.; March 2020.
2. Genotropin [package insert]. New York, NY: Pfizer, Inc.; January 2020.
3. Humatrope [package insert]. Indianapolis, IN: Lilly USA, LLC; October 2019.
4. Nutropin AQ [package insert]. South San Francisco, CA: Genentech, Inc.; December 2016.
5. Omnitrope [package insert]. Princeton, NJ: Sandoz, Inc.; June 2019.
6. Saizen [package insert]. Rockland, MA: EMD Serono, Inc.; February 2020.
7. Skytrofa [package insert]. Palo Alto, CA: Ascendis Pharma, Inc.; August 2022.
8. Sogroya [package insert]. Plainsboro, NJ: Novo Nordisk, Inc.; October 2021.
9. Zomacton [package insert]. Parsippany, NJ: Ferring Pharmaceuticals, Inc.; July 2018.