

**This document applies to the following:**

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control – Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input type="checkbox"/>
Advanced Control Specialty – Choice (ACSCF)	<input type="checkbox"/>
Managed Medicaid Template (MMT)	<input checked="" type="checkbox"/>
Marketplace (MF)	<input checked="" type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input type="checkbox"/>
Aetna Health Exchange (AHE)	<input type="checkbox"/>
Aetna Individual Lives (IVL)	<input type="checkbox"/>
Value (VF)	<input type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input type="checkbox"/>
Medical Benefit	<input type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Medical Benefit: Managed Medicaid (MMMB)	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part B: Advanced Biosimilars First	<input type="checkbox"/>

# Exceptions Criteria

## Growth Hormone

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

These criteria were developed to align with the following: Managed Medicaid Template (MMT) and Marketplace (MF).

## Plan Design Summary

This program applies to the growth hormone products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products 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

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

Reference number(s)
5734-D

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

## 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 the requested drug is Nutropin AQ and is being prescribed for a member with chronic kidney disease.

## References

1. Genotropin [package insert]. New York, NY: Pfizer, Inc.; August 2024.
2. Humatrope [package insert]. Indianapolis, IN: Lilly USA, LLC; December 2023.
3. Ngenla [package insert]. New York, NY: Pfizer, Inc; June 2023.
4. Norditropin [package insert]. Plainsboro, NJ: Novo Nordisk, Inc.; March 2020.
5. Nutropin AQ [package insert]. South San Francisco, CA: Genentech, Inc.; December 2016.
6. Omnitrope [package insert]. Princeton, NJ: Sandoz, Inc.; March 2024.
7. Saizen [package insert]. Rockland, MA: EMD Serono, Inc.; February 2020.
8. Skytrofa [package insert]. Palo Alto, CA: Ascendis Pharma, Inc.; May 2024.
9. Sogroya [package insert]. Plainsboro, NJ: Novo Nordisk, Inc.; April 2023.
10. Zomacton [package insert]. Parsippany, NJ: Ferring Pharmaceuticals, Inc.; April 2024.