Clinical Policy: Human Growth Hormone (Somapacitan, Somatrogon, Somatropin, Lonapegsomatropin-tcgd)

Reference Number: CP.PHAR.517
Effective Date: 03.01.21
Last Review Date: 08.24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following human growth hormone (hGH) formulations require prior authorization:

- hGH analogs: somapacitan-beco (Sogroya®), somatrogon-ghla (Ngenla™)
- Recombinant hGH (rhGH) formulations: somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin AQ® NuSpin®, Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®), longpegsomatropin-tcgd (Skytrofa®)

Drugs	Children								Adults		
	GHD	PWS	TS	NS	SHOX	CKD	SGA	ISS	GHD	HIV	SBS
Sogroya	GF								X		
Genotropin	GF	GF	GF				GF	GF	X		
Humatrope	GF		SS		SS/GF		SS	SS/GF	X		
Ngenla	GF										
Norditropin	GF	GF	SS	SS			SS	SS	X		
NutropinAQ NuSpin	GF		GF			GF		GF	X		
Omnitrope	GF	GF	GF				GF	GF	X		
Saizen	GF								X		
Serostim										X	
Skytrofa	GF										
Zomacton	GF		SS		SS		SS	SS	X		
Zorbtive											X

Abbreviations: CKD: chronic kidney disease, GF: growth failure, GHD: growth hormone deficiency, HIV: human immunodeficiency virus, ISS: idiopathic short stature, NS: Noonan syndrome, PWS: Prader-Willi syndrome, SBS: short bowel syndrome, SGA: small for gestational age, SHOX: short stature homeobox-containing gene, SS: short stature, TS: Turner syndrome

FDA Approved Indication(s)

hGH Analogs:

Sogroya is indicated for:

- Treatment of pediatric patients aged 2.5 years and older who have GF due to inadequate secretion of endogenous GH
- Replacement of endogenous GH in adults with GHD

Ngenla is indicated for:

- Treatment of pediatric patients aged 3 years and older who have GF due to inadequate secretion of endogenous GH

rhGH Formulations:
Genotropin is indicated for treatment of:
- Children with GF due to GHD, PWS, SGA, TS, and ISS.
- Adults with either childhood-onset (CO) or adult-onset (AO) GHD.

Humatrope is indicated for treatment of:
- Pediatric patients: GF due to inadequate secretion of endogenous GH; SS associated with TS; ISS, high standard deviation score (SDS) <- 2.25, and associated with growth rates unlikely to permit attainment of adult height in the normal range; SS or GF in SHOX deficiency; SS born small for SGA with no catch-up growth by 2 years to 4 years of age.
- Replacement of endogenous GH in adults with GHD.

Norditropin FlexPro is indicated for the treatment of:
- Children with GF due to GHD, SS associated with NS, SS associated with TS, SS born SGA with no catch-up growth by age 2 to 4 years, ISS, and GF due to PWS.
- Replacement of endogenous GH in adults with GHD.

Nutropin AQ NuSpin is indicated for the treatment of:
- Children with GF due to GHD, ISS, TS, and CKD up to the time of renal transplantation.
- Adults with either CO or AO GHD.

Omnitrope is indicated for the treatment of:
- Children with GF due to GHD, PWS, SGA, TS, and ISS.
- Adults with either CO or AO GHD.

Saizen is indicated for:
- Children with GF due to GHD.
- Adults with either CO or AO GHD.

Serostim is indicated for treatment of:
- HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance.

Skytrofa is indicated for treatment of:
- Pediatric patients 1 year and older who weigh at least 11.5 kg and have GF due to inadequate secretion of endogenous GH.

Zomacton is indicated for:
- Treatment of pediatric patients who have GF due to inadequate secretion of endogenous GH, SS associated with TS, ISS, SS or GF in SHOX deficiency, and SS born SGA with no catch-up growth by 2 years to 4 years.
- Replacement of endogenous GH in adults with GHD.

Zorbtive is indicate for treatment of:

- SBS in adult patients receiving specialized nutritional support.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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It is the policy of health plans affiliated with Centene Corporation® that Skytrofa, Sogroya, Ngenla, and somatropin are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Growth Hormone Deficiency with Neonatal Hypoglycemia (off-label) (must meet all)**:**

1. Diagnosis of neonatal hypoglycemia due to GHD;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a pediatric endocrinologist;
4. Age ≤ 1 month;
5. Serum GH concentration ≤ 5 µg/L;
6. Member meets one of the following (a or b):
   a. Imaging shows hypothalamic-pituitary abnormality;
   b. Deficiency of ≥ 1 anterior pituitary hormone other than GH (e.g., ACTH, TSH, LH, FSH, prolactin);

7. The requested product is not prescribed concurrently with Increlex® (mecasermin);
8. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
9. Dose does not exceed 0.30 mg/kg per week.

Approval duration: 12 months

B. Growth Hormone Deficiency with Short Stature/Growth Failure - Children *(open epiphyses)* (must meet all)**:**

1. Diagnosis of GHD;
2. Prescribed by or in consultation with a pediatric endocrinologist;
3. Age < 18 years;
4. If request is for Skytrofa, age ≥ 1 years and weight ≥ 11.5 kg;
5. If request is for Sogroya, age ≥ 2.5 years;
6. If request is for Ngenla, age ≥ 3 years;
7. If age > 10 years, open epiphysis on x-ray;
8. Member meets one of the following (a or b):
   a. Low insulin-like growth factor (IGF)-I serum level;
   b. Low insulin-like growth factor binding protein (IGFBP)-3 serum level;
9. Member meets one of the following (a, b, c, d, or e):
   a. Two GH stimulation tests with peak serum levels ≤ 10 µg/mL (e.g., stimulants: arginine, clonidine, glucagon);
   b. Deficiency of ≥ 3 pituitary hormones (i.e., ACTH, TSH, LH, FSH, prolactin);
   c. Prior surgery or radiotherapy to the hypothalamic-pituitary region;
   d. Imaging shows hypothalamic-pituitary abnormality;
   e. GHD-specific mutation (e.g., POU1F1, PROP1, LHX3, LHX4, HESX1, OTX2, TBX19, SOX2, SOX3, GLI2, GHRHR, GH1);
10. Member meets one of the following (a or b):
    a. SS: height is > 2 SD below the mean for age and sex (SD, height, date, and age in months within the last 90 days are required);
    b. GF: one of the following (i, ii, or iii):
       i. Height deceleration across two growth chart percentiles representing > 1 SD below the mean for age and sex (SD and 2 heights, dates, and ages in months at least 6 months apart within the last year are required);
       ii. Growth velocity > 2 SD below the mean for age and sex over 1 year (SD and 2 heights, dates, and ages in months at least 1 year apart within the last year are required);
       iii. Growth velocity > 1.5 SD below the mean for age and sex sustained over 2 years (SD and 2 heights, dates, and ages in months at least 2 years apart within the last two years are required);

11. The requested product is not prescribed concurrently with Increlex (mecasermin);
12. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
    a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
        i. Zomacton;
        ii. Omnitrope vial;
    b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

    **Prior authorization may be required for Zomacton and Omnitrope*
13. Dose does not exceed one of the following (a, b, c, or d):
    a. For Ngenla: 0.66 mg/kg per week;
    b. For Skytrofa: 0.24 mg/kg per week;
    c. For Sogroya: 0.16 mg/kg per week;
    d. For somatropin agents: 0.30 mg/kg per week.

Approval duration: 12 months

C. Genetic Disorders with Short Stature/Growth Failure - Children (must meet all)**:**
1. Diagnosis of PWS, TS, NS, or SHOX deficiency confirmed by a genetic test;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a pediatric endocrinologist;
4. Age < 18 years;
5. If age > 10 years, open epiphysis on x-ray;
6. Member meets one of the following (a or b):
    a. SS: height is > 2 SD below the mean for age and sex (> 1.5 SD if TS) (SD, height, date, and age in months within the last 90 days are required);
    b. GF: one of the following (i, ii, or iii):
        i. Height deceleration across two growth chart percentiles representing > 1 SD below the mean for age and sex (SD and 2 heights, dates, and ages in months at least 6 months apart within the last year are required);
        ii. Growth velocity > 2 SD below the mean for age and sex over 1 year (SD and 2 heights, dates, and ages in months at least 1 year apart within the last year are required);
        iii. Growth velocity > 1.5 SD below the mean for age and sex sustained over 2 years (SD and 2 heights, dates, and ages in months at least 2 years apart within the last two years are required);
7. The requested product is not prescribed concurrently with Increlex (mecasermin);
8. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
    a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
        i. Zomacton;
        ii. Omnitrope vial;
    b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

    **Prior authorization may be required for Zomacton and Omnitrope*

9. Request meets one of the following (a, b, or c):
    a. PWS: Dose does not exceed 0.24 mg/kg per week;
    b. TS, NS: Dose does not exceed 0.5 mg/kg per week;
    c. SHOX deficiency: Dose does not exceed 0.35 mg/kg per week.

Approval duration: 12 months

D. Chronic Kidney Disease with Growth Failure – Children (must meet all)**:**

1. Diagnosis of CKD;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a pediatric endocrinologist or nephrologist;
4. Age < 18 years;
5. If age > 10 years, open epiphysis on x-ray;
6. Member meets one of the following (a, b, c, or d):
    a. GFR < 60 mL/min per 1.73 m^2 for ≥ 3 months;
    b. Dialysis dependent;
    c. Diagnosis of nephropathic cystinosis;
    d. History of kidney transplant ≥ 1 year ago;
7. Member meets one of the following (a or b):
    a. SS: height is > 2 SD below the mean for age and sex (SD, height, date, and age in months within the last 90 days are required);
    b. GF: one of the following (i, ii, or iii):
        i. Height deceleration across two growth chart percentiles representing > 1 SD below the mean for age and sex (SD and 2 heights, dates, and ages in months at least 6 months apart within the last year are required);
        ii. Growth velocity > 2 SD below the mean for age and sex over 1 year (SD and 2 heights, dates, and ages in months at least 1 year apart within the last year are required);
        iii. Growth velocity > 1.5 SD below the mean for age and sex sustained over 2 years (SD and 2 heights, dates, and ages in months at least 2 years apart within the last two years are required);
8. The requested product is not prescribed concurrently with Increlex (mecasermin);
9. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
    a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii):
        i. Zomacton;
        ii. Omnitrope vial;
    b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

    **Prior authorization may be required for Zomacton and Omnitrope*
10. Dose does not exceed 0.35 mg/kg per week.

Approval duration: 12 months

E. Born Small for Gestational Age with Short Stature/Growth Failure - Children (must meet all)**:**

1. Diagnosis of SGA:

2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a pediatric endocrinologist;
4. Age ≥ 2 years and < 18 years;
5. If age > 10 years, open epiphysis on x-ray;
6. Birth weight or length > 2 SD below the mean for gestational age (SD, birth weight or length, and gestational age are required);
7. Current height > 2 SD below the mean for age and sex measured within the last year at ≥ 2 years of age (SD, height, date, and age in months are required);
8. The requested product is not prescribed concurrently with Increlex (mecasermin);
9. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii):
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
10. Dose does not exceed 0.48 mg/kg per week.

Approval duration: 12 months

F. Growth Hormone Deficiency – Adults and Transition Patients *(closed epiphyses)* (must meet all):

1. Diagnosis of GHD;
2. Request is for a somatropin or somapacitan formulation;
3. Prescribed by or in consultation with an endocrinologist;
4. Age ≥ 18 years OR closed epiphysis on x-ray;
5. Member has NOT received somatropin therapy for ≥ 1 month prior to GH/IGF-I testing as outlined below;
6. Member meets one of the following (a, b, or c):
   a. Two fasting a.m. GH stimulation tests with peak serum levels ≤ 5 µg/mL (accepted stimulants: Macrilen™ [macimorelin] or combination of 2 stimulants such as arginine + glucagon);
   b. Both of the following (i and ii):
      i. One fasting a.m. GH stimulation test with peak serum level ≤ 5 µg/ml (accepted stimulants: Macrilen [macimorelin] or combination of 2 stimulants such as arginine + glucagon);
      ii. One low IGF-I serum level;
   c. One low IGF-I serum level and one of the following (i, ii, or iii):
      i. Imaging shows hypothalamic-pituitary abnormality;
      ii. Deficiency of ≥ 3 pituitary hormones (i.e., ACTH, TSH, LH, FSH, prolactin);
      iii. GHD-specific mutation (e.g., POU1F1, PROP1, LHX3, LHX4, HESX1, OTX2, TBX19, SOX2, SOX3, GLI2, GHRHR, GH1);
7. The requested product is not prescribed concurrently with Increlex (mecasermin);
8. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):

a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
   i. Zomacton;
   ii. Omnitrope vial;
b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

**Prior authorization may be required for Zomacton and Omnitrope*

9. Dose does not exceed one of the following (a or b):
   a. For Sogroya: 8 mg once weekly;
   b. For somatropin formulations: 0.4 mg/day (may adjust by up to 0.2 mg/day every 4 weeks to maintain normal IGF-1 serum levels; doses > 1.6 mg/day would be uncommon).

Approval duration: 6 months

G. Short Bowel Syndrome (must meet all):
1. Diagnosis of SBS;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a gastroenterologist;
4. Age ≥ 18 years;
5. Patient is dependent upon and receiving intravenous nutrition;
6. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
7. Dose does not exceed 8 mg per day.

Approval duration: up to 4 weeks total

H. HIV-Associated Wasting or Cachexia (must meet all):
1. Diagnosis of HIV;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a physician specializing in HIV management;
4. Age ≥ 18 years;
5. Member meets one of the following (a, b, or c):
   a. Unintentional weight loss of ≥ 10% in the last 12 months occurring while on antiretroviral therapy;
   b. Weight < 90% of the lower limit of ideal body weight;
   c. Body mass index (BMI) ≤ 20 kg/m^2;
6. Failure of at least 2 pharmacologic therapies from two separate drug classes *(Appendix B)* unless contraindicated or clinically adverse effects are experienced;
7. Member is currently on antiretroviral therapy;

8. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
9. Prescribed dose does not exceed 6 mg per day.

Approval duration: 6 months (up to 12 months total)

I. Other diagnoses/indications (must meet 1 and 2)**:**

1. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
2. Member meets one of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Pediatric Indications *(open epiphyses)* (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Member receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Age < 18 years OR open epiphysis on x-ray;

3. Member meets one of the following (a or b):
   a. For diagnosis of neonatal hypoglycemia, when member has received somatropin therapy for ≥ 2 years, member's height has increased ≥ 2 cm in the last year as documented by 2 height measurements taken no more than 1 year apart (dates and height measurements required);
   b. For all other pediatric diagnoses, member's height has increased ≥ 2 cm in the last year as documented by 2 height measurements taken no more than 1 year apart (dates and height measurements required);
4. If request is for a dose increase, request meets one of the following (a, b, c, d, or e):
   a. GHD, one of the following (i, ii, iii, or iv):
      i. For Ngenla (without neonatal hypoglycemia): New dose does not exceed 0.66 mg/kg per week;
      ii. For Skytrofa (without neonatal hypoglycemia): New dose does not exceed 0.24 mg/kg per week;
      iii. For Sogroya (without neonatal hypoglycemia): New dose does not exceed 0.16 mg/kg per week;
      iv. For somatropin agents (with or without neonatal hypoglycemia): New dose does not exceed 0.30 mg/kg per week;
   b. PWS: New dose does not exceed 0.24 mg/kg per week;
   c. TS, NS: New dose does not exceed 0.5 mg/kg per week;
   d. SHOX deficiency, CKD: New dose does not exceed 0.35 mg/kg per week;
   e. Born SGA: New dose does not exceed 0.48 mg/kg per week.

Approval duration: 12 months

B. Growth Hormone Deficiency - Adults and Transition Patients *(closed epiphyses)* (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. For IGF-1 test results and dosing (test conducted within the last 90 days), one of the following (a, b, or c):
   a. Low IGF-1 serum level (i or ii):
      i. For Sogroya: 8 mg once weekly;
      ii. For somatropin formulations: If request is for a dose increase, new dose does not exceed an incremental increase of more than 0.2 mg/day and a total dose of 1.6 mg/day;
   b. Normal IGF-1 serum level: Requested dose is for the same or lower dose;
   c. Elevated IGF-1 serum level: Requested dose has been titrated downward.

Approval duration: 12 months

C. Short Bowel Syndrome - Adults (must meet all)**:**
1. Member meets one of the following (a or b):

a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. Member is responding positively to therapy;
3. Member has not received the requested product for ≥ 4 weeks;
4. If request is for a dose increase, new dose does not exceed 8 mg per day.

Approval duration: up to 4 weeks total

D. HIV-Associated Wasting/Cachexia - Adults (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Member has not received ≥ 12 months of therapy;
4. If request is for a dose increase, new dose does not exceed 6 mg per day.

Approval duration: 12 months (up to 12 months total)

E. Other diagnoses/indications (must meet 1 and 2)**:**

1. If request is NOT for Zomacton or Omnitrope vial, either of the following (a or b):
   a. Member must use both of the following, unless clinically adverse effects are experienced or both are contraindicated (i and ii)*:
      i. Zomacton;
      ii. Omnitrope vial;
   b. If both Zomacton and Omnitrope vial are not available (e.g., due to drug shortages), member must use Omnitrope* pen cartridge, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization may be required for Zomacton and Omnitrope*
2. Member meets one of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
      i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- **A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;
- **B.** Idiopathic short stature (ISS);
- **C.** Constitutional delay of growth and puberty (i.e., constitutional growth delay; the member's growth rate is delayed compared to chronological age but appropriate for bone age as determined by x-ray);
- **D.** Familial (genetic) short stature (i.e., height velocity and bone age, as determined by x-ray, are within the normal range and one or both parents are short);
- **E.** Adult short stature or altered body habitus associated with antiviral therapy (other than HIV-associated wasting or cachexia);
- **F.** Obesity treatment or enhancement of body mass/strength for non-medical reasons (e.g., athletic gains).

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AO: adult-onset
CKD: chronic kidney disease
CO: childhood-onset
FDA: Food and Drug Administration
GF: growth failure
GFR: glomerular filtration rate
GH: growth hormone
GHD: growth hormone deficiency
hGH: human growth hormone
HIV: human immunodeficiency virus
IGF-1: insulin-like growth factor-1
IGFBP-3: insulin-like growth factor binding protein-3
ISS: idiopathic short stature
NS: Noonan syndrome
PWS: Prader-Willi syndrome
rhGH: recombinant human growth hormone
SBS: short bowel syndrome
SD: standard deviation
SGA: small for gestational age
SHOX: short stature homeobox-containing gene
SS: short stature
TS: Turner syndrome

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug*	Dosing Regimen	Dose Limit/Maximum Dose
Appetite Stimulants		
megestrol (Megace®, Syndros®)	400 - 800 mg PO daily (10 – 20 ml/day)	800 mg/day
dronabinol (Marinol®)	2.5 mg PO BID	20 mg/day
Testosterone Replacement Products		
testosterone enanthate or cypionate (various brands)	50 - 400 mg IM Q2 – 4 wks	400 mg Q 2 wks

Drug*	Dosing Regimen	Dose Limit/Maximum Dose
Androderm® (testosterone transdermal patch)	2.5 – 7.5 mg patch applied topically QD	7.5 mg/day
testosterone transdermal gel (Androgel®, Testim®)	5 - 10 gm gel (delivers 50 – 100 mg testosterone) applied topically QD	10 gm/day gel (100 mg/day testosterone)
Anabolic Steroids		
oxandrolone (Oxandrin®)	2.5 – 20 mg PO /day	20 mg/day
Nausea/Vomiting Treatments		
chlorpromazine	10 to 25 mg PO q4 to 6 hours prn	2,000 mg/day
perphenazine	8 to 16 mg/day PO in divided doses	64 mg/day
prochlorperazine	5 to 10 mg PO TID or QID	40 mg/day
promethazine	12.5 to 25 mg PO q4 to 6 hours prn	50 mg/dose; 100 mg/day
trimethobenzamide	300 mg PO TID or QID prn	1,200 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Preferred status may be formulary-specific.*

Appendix C: Contraindications/Boxed Warnings

- Contraindications:
  - Acute critical illness
  - Children with PWS who are severely obese, have history of upper airway obstruction or sleep apnea, or have severe respiratory impairment due to risk of sudden death
  - Active malignancy
  - Hypersensitivity to product or any of the excipients
  - Active proliferative or severe non-proliferative diabetic retinopathy
  - Children with closed epiphyses
- Boxed warning(s): none reported

Appendix D: Short Stature and Growth Failure

- For SS, the policy follows the World Health Organization (WHO) definition of > 2 SD below the mean for age and sex.[1]
- For GF, the policy follows
  - Haymond et al (2013) and Rogol et al (2014) for height deceleration across two major percentiles representing a change of > 1 SD corrected for age and sex[2,3] and
  - the Growth Hormone Research Society (2000) for height velocity in the absence of SS that would prompt further investigation, namely, a height velocity > 2 SD below the mean over 1 year or > 1.5 SD below the mean sustained over 2 years for age and sex.[4]
- The Centers for Disease Control and Prevention (CDC) recommend WHO growth charts for infants and children age 0 to < 2 years and CDC growth charts for children age 2 years to < 20 years in the U.S.[5]

- Based on CDC recommended growth chart data, SD approximations of major height percentiles falling below the mean are listed below:
  - 2nd percentile: 2 SD below the mean
  - 5th percentile: 1.5 SD below the mean
  - 15th percentile: 1 SD below the mean
  - 30th percentile: 0.5 SD below the mean
  - 50th percentile: 0 SD mean
- CDC recommended growth charts, data tables, and related information that may be helpful in assessing length, height and growth are available at the following link: https://www.cdc.gov/growthcharts/index.htm.

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V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Pediatric Indications (Subcutaneous administration; weekly doses should be divided [except Skytrofa, Sogroya and Ngenla])			
Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Zomacton	GHD	G, O: 0.16 to 0.24 mg/kg/week H, Z: 0.18 to 0.30 mg/kg/week N: 0.17 to 0.24 mg/kg/week Nu: to 0.30 mg/kg/week S: 0.18 mg/kg/week	See dosing regimens
Genotropin, Norditropin, Omnitrope	PWS	G, N, O: 0.24 mg/kg/week	0.24 mg/kg/week
Genotropin, Humatrope, Norditropin, Omnitrope, Zomacton	SGA	G, O: to 0.48 mg/kg/week H, N, Z: to 0.47 mg/kg/week	0.48 mg/kg/week
Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Zomacton	TS	G, O: 0.33 mg/kg/week H, Nu, Z: to 0.375 mg/kg/week N: to 0.47 mg/kg/week	See dosing regimens
Genotropin, Humatrope,	ISS	G, O, No: to 0.47 mg/kg/week H, Z: to 0.37 mg/kg/week Nu: to 0.30 mg/kg/week	See dosing regimens

Drug Name	Indication	Dosing Regimen	Maximum Dose
Norditropin, Nutropin, Omnitrope, Zomacton			
Humatrope, Zomacton	SHOX	H, Z: 0.35 mg/kg/week	0.35 mg/kg/week
Norditropin	NS	0.46 mg/kg/week	0.46 mg/kg/week
Nutropin	CKD	0.35 mg/kg/week	0.35 mg/kg/week
Skytrofa	GHD	0.24 mg/kg/week	0.24 mg/kg/week
Sogroya	GHD	0.16 mg/kg once weekly	0.16 mg/kg/week
Ngenla	GHD	0.66 mg/kg once weekly	0.66 mg/kg/week
Adult Indications (Subcutaneous administration)			
Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Zomacton	GHD	0.4 mg/day - may adjust by increments up to 0.2 mg/day every 6 weeks to maintain normal IGF-1 serum levels.* _____ **Dosing regimen from Endocrine Society guidelines (Fleseriu, et al., 2016).* Adult GHD dosing should be substantially lower than that prescribed for children. Adult doses beyond 1.6 mg/day would be uncommon.	See dosing regimen
Serostim	HIV-associated wasting	0.1 mg/kg QOD or QD to 6 mg QD	6 mg/day up to 24 weeks
Sogroya	GHD	1.5 mg once weekly – increase by increments of 0.5-1.5 mg every 2-4 weeks based on clinical response and serum IGF-1 concentrations	8 mg/week
Zorbtive	SBS	0.1 mg/kg QD to 8 mg QD	8 mg/day up to 4 weeks

Abbreviations: G: genotropin, H: humatrope, N: norditropin, Nu: nutropin, O: omnitrope, S: saizen, Z: zomacton

VI. Product Availability

Drug	Availability*
hGH Analogs	
Sogroya	MD pens: 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL
rhGH Formulations	
Genotropin lyophilized powder	MD dual-chamber syringes: 5 mg, 12 mg
Genotropin Miniquick	SD pen cartridges: 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1.0 mg, 1.2 mg, 1.4 mg, 1.6 mg. 1.8 mg, 2.0 mg
Humatrope	MD pen cartridges: 6 mg, 12 mg, 24 mg MD vial: 5mg

Drug	Availability*
Ngenla	MD pens: 24 mg/1.2 mL, 60 mg/1.2 mL
Norditropin Flexpro	MD pens: 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL, 30 mg/3 mL
Nutropin AQ NuSpin	MD NuSpin: 5 mg/2 mL, 10 mg/2 mL, 20 mg/2 mL MD pen cartridges: 10 mg/2 mL, 20 mg/2 mL
Omnitrope	MD pen cartridges: 5 mg/1.5 mL, 10 mg/1.5 mL MD vials: 5.8 mg
Saizen	MD pen cartridges: 8.8 mg MD vials: 5 mg, 8.8 mg
Serostim	MD vial: 4 mg SD vials: 5 mg, 6 mg
Skytrofa	SD prefilled cartridges: 3 mg, 3.6 mg, 4.3 mg, 5.2 mg, 6.3 mg, 7.6 mg, 9.1 mg, 11 mg, 13.3 mg
Zomacton	MD vials: 5 mg, 10 mg
Zorbtive	MD vials: 8.8 mg

SD: single-dose, MD: multidose

VII. References

FDA Labels

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Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2941	Injection, somatropin, 1 mg
C9399	Unclassified drugs or biologics
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy CP.PHAR.55 Somapacitan beco, Somatropin (Human Growth Hormones); retired CP.PHAR.55 Somapacitan beco, Somatropin (Human Growth Hormones); no significant changes from previously approved policy; 1Q 2021 annual review: no significant changes; added coding implications; references reviewed and updated.	10.22.20	02.21
1Q 2022 annual review: WCG.CP.PHAR.55 retired; modified Zomacton redirection to state member must use per template language; for adult GHD continuation of therapy added requirement that member is responding positively to therapy; RT4 Sogroya added new 5 mg/1.5 mL formulation; references reviewed and updated.	10.11.21	02.22
Per February SDC and prior clinical guidance, added additional stepwise redirection to Omnitrope vial if Zomacton is not available (e.g., due to drug shortages).	02.17.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.03.22	
1Q 2023 annual review: FDA indication updated for Humatrope; for HIV-associated wasting or cachexia added criteria member is currently on antiretroviral therapy and for initial approval added restriction of (up to 12 months total); references reviewed and updated.	11.14.22	02.23
RT4: per updated label for Sogroya – added pediatric extension for GF due to GHD and new 15 mg/1.5 mL strength, for pediatric GHD criteria set added Sogroya specific age limit and dosing, and updated Appendix C with Sogroya pediatric contraindications.	05.17.23	
RT4: added Ngenla to policy.	07.06.23	
1Q 2024 annual review: for HIV-associated wasting or cachexia, added options for member to meet criteria if weight < 90% of the lower limit of ideal body weight or BMI ≤ 20 kg/m^2; added HCPCS/CPT code [C9399, J3590]; references reviewed and updated.	10.13.23	02.24
Added Skytrofa to policy. Per June SDC, added redirection to Omnitrope vial to co-prefer Zomacton and Omnitrope vial; revised Omnitrope vial to Omnitrope pen	06.06.24	08.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
cartridge if Zomacton and Omnitrope vial are not available (e.g., due to drug shortage); added redirection to other diagnoses/indications sections for both initial and continuation requests.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.