GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
GROWTH HORMONES PA SUMMARY

Preferred	Non-Preferred
Genotropin (somatropin) Norditropin (somatropin)	Humatrope (somatropin) Ngenla (somatrogon-ghla) Nutropin AQ (somatropin) Omnitrope (somatropin) Saizen (somatropin) Serostim (somatropin) Skytrofa (lonapegsomatropin) Sogroya (somapacitan-beco) Zomacton (somatropin) Zorbtive (somatropin)

The drug names above include all available cartridge and pen formulations under the same primary name.

LENGTH OF AUTHORIZATION: Varies

NOTES:

- All preferred and non-preferred growth hormones require prior authorization.

PA CRITERIA:

Genotropin and Norditropin

- Approvable diagnoses for children are as follows:
  - Growth hormone deficiency or short stature
  - Short stature related to Turner's Syndrome
  - Growth failure with chronic renal insufficiency
  - Previous radiation to the brain
  - Prader-Willi Syndrome in members who have been screened for sleep apnea by a sleep oximetry study or polysymnography and who do not have contraindications to therapy
  - Short stature homeobox gene (SHOX)
  - Decreased pituitary function
  - Intrauterine growth retardation, small for gestational age
  - Born without a pituitary gland, history of a hypophysectomy or panhypopituitarism
- Member must have been evaluated by a pediatric endocrinologist.
- Approvable diagnoses for adults are as follows:
  - Somatropin Deficiency Syndrome
  - Short stature related to Turner's Syndrome
  - Previous radiation to the brain
  - Born without a pituitary gland, history of a hypophysectomy or panhypopituitarism

Humatrope, Nutropin AQ, Omnitrope, Saizen and Zomacton

- In addition to the same criteria as above, member must have experienced inadequate response, contraindications or drug-drug-interactions with Genotropin and Norditropin.

Ngenla, Skytrofa and Sogroya

- Approvable for members 1 to 2 years of age with a diagnosis of growth hormone deficiency or short stature whose pretreatment height is below the third percentile, whose pretreatment growth rate is less than 7 cm/year and whose predicted adult height based on bone age X-ray is less than the third percentile and who have experienced inadequate response, contraindications or drug-drug-interactions with Genotropin and Norditropin.
- Approvable for members 3 to 17 years of age with a diagnosis of growth hormone deficiency or short stature whose pretreatment height is below the third percentile, whose pretreatment growth rate is less than 4 cm/year and whose pretreatment X-rays of the left hand and wrist have shown that the bone age is greater than or equal to two standard deviations below the mean for the chronological age (this is generally greater than 2 years delayed growth) and who have experienced inadequate response, contraindications or drug-drug-interactions with Genotropin and Norditropin.
- Member must have been evaluated by a pediatric endocrinologist.
- In addition for Skytrofa, member must have experienced inadequate response, contraindications or drug-drug interactions with Ngenla and Sogroya.

Serostim

- Approvable for members with a diagnosis of HIV wasting or cachexia who are receiving nutritional support and antiretroviral therapy (ART); ***AND***
- Member has experienced at least 7.5% unintentional weight loss over the past 6 months, 10% unintentional weight loss over the past 12 months, 5% body cell mass (BCM) loss over the past 6 months OR body mass index (BMI) less than 20 kg/m^2; ***AND***
- Member's weight loss is not due to another underlying treatable condition (e.g., depression, infection, chronic diarrhea, malignancy); ***AND***
- Member has tried another therapy for HIV wasting/cachexia (e.g., dronabinol, megestrol, testosterone) and failed to achieve an adequate response or the member has allergies, contraindications, drug-drug interactions or intolerable side effects to other therapies for HIV wasting/cachexia; ***AND***
- Medication is prescribed by or in consultation with a specialist in managing HIV.

Zorbtive

- Approvable for members 18 years of age or older with a diagnosis of short bowel syndrome who are receiving specialized nutritional support (e.g., high carbohydrate low-fat diet) and optimal management (e.g., dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient/electrolyte replacement).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.