



**GEORGIA MEDICAID FEE-FOR-SERVICE  
GROWTH HORMONES PA SUMMARY (EXCEPT SEROSTIM)**

Preferred	Non-Preferred
Genotropin Norditropin Nutropin AQ	Humatrope Omnitrope Saizen Skytrofa Zomacton Zorbtive

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:**

Preferred Products

- ❖ 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
- ❖ For requests for children for a repeat course of therapy, must be able to demonstrate that member's growth rate doubled in the first year of growth hormone therapy OR increased by at least 3 cm/year in the first year of growth hormone therapy.
- ❖ 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

Non-Preferred Products (except Skytrofa and Zorbtive)

- ❖ In addition to the same criteria as for preferred products above, member must have experienced ineffectiveness, contraindications, or drug-drug-interactions with at least two preferred products.



### Skytrofa

- ❖ 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 ineffectiveness, contraindications or drug-drug-interactions with at least two preferred products.
- ❖ 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 ineffectiveness, contraindications or drug-drug-interactions with at least two preferred products.
- ❖ Member must have been evaluated by a pediatric endocrinologist.

### Zorbtive

- ❖ Approvable for members 18 years of age or older with a diagnosis of short bowel syndrome who are receiving specialized nutritional support and optimal management.

### **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](http://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](http://www.mmis.georgia.gov/portal), highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.