Clinical Policy: Somatropin and Somapacitan (Human Growth Hormone)

Reference Number: IL.PHAR.55
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Line of Business: Medicaid

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®)
- Recombinant hGH (rhGH) formulations: somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin AQ® NuSpin®,Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®)

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	SS/GF		SS/GF		SS/GF		SS/GF	SS/GF	X		
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	
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:

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

rhGH Formulations:

Genotropin is indicated for:

- Pediatric Patients: Treatment of children with growth failure due to growth hormone deficiency (GHD), Prader-Willi syndrome, Small for Gestational Age, Turner syndrome, and Idiopathic Short Stature

- Adult Patients: Treatment of adults with either childhood-onset or adult-onset GHD

Humatrope is indicated for:
- Pediatric Patients: Treatment of children with short stature or growth failure associated with growth hormone (GH) deficiency, Turner syndrome, idiopathic short stature (ISS), short stature homeobox-containing gene (SHOX) deficiency, and failure to catch up in height after small for gestational age birth
- Adult Patients: Treatment of adults with either childhood-onset or adult-onset GHD

Norditropin FlexPro is indicated for:
- Pediatric Patients: Treatment of children with growth failure due to GHD, short stature associated with Noonan syndrome, short stature associated with Turner syndrome, and short stature born small for gestational age with no catch-up growth by age 2 to 4 years, Idiopathic Short Stature (ISS), and growth failure due to Prader-Willi Syndrome
- Adult Patients: Treatment of adults with either childhood-onset or adult-onset GHD

Nutropin AQ NuSpin is indicated for:
- Pediatric Patients: Treatment of children with growth failure due to GHD, ISS, Turner syndrome (TS), and chronic kidney disease (CKD) up to the time of renal transplantation
- Adult Patients: Treatment of adults with either childhood-onset or adult-onset GHD

Omnitrope is indicated for:
- Pediatric Patients: Treatment of children with growth failure due to GHD, Prader-Willi Syndrome, Small for Gestational Age, TS, and ISS
- Adult Patients: Treatment of adults with either childhood-onset or adult-onset GHD

Saizen is indicated for:
- Pediatric Patients: Treatment of children with growth failure due to GHD
- Adult Patients: Treatment of adults with either childhood-onset or adult-onset 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

Zomacton is indicated for:
- Pediatric Patients: Treatment of pediatric patients who have growth failure due to inadequate secretion of normal endogenous GH, short stature associated with TS, ISS, SS or GF in SHOX deficiency, and short stature born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years
- Adult Patients: For replacement of endogenous GH in adults with GH deficiency

Zorbtive is indicate for:
- For the treatment of Short Bowel Syndrome (SBS) in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of SBS.

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.

It is the policy of health plans affiliated with Centene Corporation® that Sogroya and somatropin (recombinant human growth hormone (rhGH)) 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 for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin;
   **PA may be required for Genotropin*
9. Dose does not exceed the maximum indicated in the prescribing information.

Approval duration: 12 months

B. Growth Hormone Deficiency with Short Stature/Growth Failure - Children *(open epiphyses)* (must meet all)**:**
1. Diagnosis of GHD;
2. Request is for a somatropin formulation;
3. Prescribed by or in consultation with a pediatric endocrinologist;
4. Age < 18 years;
5. If request is for Sogroya, age ≥ 2.5 years;
6. If age > 10 years, open epiphysis on x-ray;
7. 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;
8. 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);

9. Member meets one of the following (a or b):
   i. 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);
   ii. 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);
10. The requested product is not prescribed concurrently with Increlex (mecasermin);
11. If request is for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin;
    **PA may be required for Genotropin*
12. Dose does not exceed one of the following (a or b):
    a. For Sogroya: 0.16 mg/kg per week;
    b. 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 for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
9. Dose does not exceed the maximum indicated in the prescribing information.

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 for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
10. Dose does not exceed the maximum indicated in the prescribing information.

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. Member meets (a and b):
   a. Birth weight or length > 2 SD below the mean for gestational age (SD, birth weight or length, and gestational age are required);
   b. 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);
7. The requested product is not prescribed concurrently with Increlex (mecasermin);
8. If request is for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
9. Dose does not exceed the maximum indicated in the prescribing information.

Approval duration: 12 months

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

1. Diagnosis of GHD;
2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 18 years OR closed epiphysis on x-ray;
4. Member has NOT received somatropin therapy for ≥ 1 month prior to GH/IGF-I testing as outlined below;
5. Member meets one of the following (a, b, or c):
   i. 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);
   ii. 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;
   iii. 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);
6. The requested product is not prescribed concurrently with Increlex (mecasermin);
7. If request is for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
8. Dose does not exceed one of the following (a or b):
   i. For Sogroya: 8 mg once weekly;

ii. 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).
iii. .

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 for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
7. Dose does not exceed the maximum indicated in the prescribing information.

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. Unintentional weight loss of ≥ 10% in the last 12 months occurring while on antiretroviral therapy;
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 for a growth hormone product other than Genotropin, the Genotropin formulations are inappropriate (e.g., due to preservatives or dosing increment limitations) or member has a contraindication or experienced clinically significant adverse effects to Genotropin; **PA may be required for Genotropin*
9. Dose does not exceed the maximum indicated in the prescribing information.

Approval duration: 6 months

I. Other diagnoses/indications
1. 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):
   a. 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
   b. 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

2. 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. Growth Hormone Use in Children (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 or ii):
      i. For Sogroya (without neonatal hypoglycemia): New dose does not exceed 0.16 mg/kg per week;
      ii. 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 – Adult 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 the maximum indicated in the prescribing information

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: up to 12 months total

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

1. 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):
   a. 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

b. 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

2. 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

CKD: chronic kidney disease
FDA: Food and Drug Administration
GFR: glomerular filtration rate
GH: growth hormone
GHD: growth hormone deficiency
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
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		

Drug*	Dosing Regimen	Dose Limit/Maximum Dose
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
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		
chlorpormazine	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

- Contraindication(s):
- Somatropin contraindications:
  - Acute critical illness
  - Children with PWS who are severely obese or have severe respiratory impairment (reports of sudden death)
  - Active malignancy
  - Product hypersensitivity
  - Active proliferative or severe non-proliferative diabetic retinopathy
  - Children with closed epiphyses
- Sogroya contraindications:
  - Acute critical illness
  - Active malignancy
  - Hypersensitivity to somapacitan-beco or excipients
  - Active proliferative or severe non-proliferative diabetic retinopathy
  - Pediatric patients with closed epiphyses

- Pediatric patients 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
- 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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1. WHO Child Growth Standards: Length/Height-for-Age, Weight-for-Age, Weight-for-Length, Weight-for-Height and Body Mass Index-for-Age: Methods and Development. Geneva, Switzerland: World Health Organization; 2006. As cited in CDC. Division of Nutrition, Physical Activity, and Obesity. Growth Chart Training: Using the WHO Growth Charts. Page last reviewed April 15, 2015. Available at https://www.cdc.gov/nccdphp/dnpao/growthcharts/who/using/assessing_growth.htm. Accessed May 1, 2020.
2. Haymond M, Kappelgaard AM, Czernichow P, et al. Early recognition of growth abnormalities permitting early intervention. Acta Pædiatrica ISSN 0803-5253. April 2013. DOI:10.1111/apa.12266.
3. Rogol AD, Hayden GF. Etiologies ad early diagnosis of short stature and growth failure in children and adolescents. J Pediatr. 2014 May;164(5 Suppl):S1-14.e6. doi: 10.1016/j.jpeds.2014.02.027.
4. Consensus guidelines for the diagnosis and treatment of growth hormone (GH) deficiency in childhood and adolescence: summary statement of the GH Research Society. JCEM. 2000; 85(11): 3990-3993.
5. Centers for Disease Control and Prevention, National Center for Health Statistics. CDC growth charts: United States. http://www.cdc.gov/growthcharts/. Accessed April 22, 2020.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Pediatric Indications (Subcutaneous administration; weekly doses should be divided) [except Sogroya])			

Drug Name	Indication	Dosing Regimen	Maximum Dose
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, Norditropin, Nutropin, Omnitrope, Zomacton	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
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
Sogroya	GHD	0.16 mg/kg once weekly	0.16 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

Drug Name	Indication	Dosing Regimen	Maximum Dose
Zorbtive	SBS	0.1 mg/kg QD to 8 mg QD	8 mg/day up to 4 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
Pediatric Indications (Subcutaneous administration; weekly doses should be divided)			
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, Norditropin, Nutropin, Omnitrope, Zomacton	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
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
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

Drug Name	Indication	Dosing Regimen	Maximum Dose
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 pen: 5 mg/1.5 mL, 10 mg/1.5 mL
rhGH Formulations	
Genotropin lyophilized powder	MD dual-chamber syringe: 5 mg, 12 mg
Genotropin Miniquick	SD pen cartridge: 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, and 2.0 mg
Humatrope	MD pen cartridge: 6 mg, 12 mg, 24 mg MD vial: 5mg
Norditropin Flexpro	MD pen: 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL, 30 mg/3 mL
Nutropin AQ NuSpin	MD: 5 mg/2 mL, 10 mg/2 mL, 20 mg/2 mL
Omnitrope	MD pen cartridge: 5 mg/1.5 mL, 10 mg/1.5 mL MD vial: 5.8 mg
Saizen	MD pen cartridge: 8.8 mg MD vial: 5 mg, 8.8 mg
Serostim	MD vial: 4 mg SD vial: 5 mg, 6 mg
Zomacton	MD vial: 5 mg, 10 mg
Zorbtive	MD vial: 8.8 mg

Drug	Availability*
hGH Analogs	
Sogroya	MD pen: 5 mg/1.5 mL, 10 mg/1.5 mL
rhGH Formulations	
Genotropin lyophilized powder	MD dual-chamber syringe: 5 mg, 12 mg
Genotropin Miniquick	SD pen cartridge: 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, and 2.0 mg
Humatrope	MD pen cartridge: 6 mg, 12 mg, 24 mg MD vial: 5mg
Norditropin Flexpro	MD pen: 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL, 30 mg/3 mL
Nutropin AQ NuSpin	MD: 5 mg/2 mL, 10 mg/2 mL, 20 mg/2 mL
Omnitrope	MD pen cartridge: 5 mg/1.5 mL, 10 mg/1.5 mL

Drug	Availability*
	MD vial: 5.8 mg
Saizen	MD pen cartridge: 8.8 mg MD vial: 5 mg, 8.8 mg
Serostim	MD vial: 4 mg SD vial: 5 mg, 6 mg
Zomacton	MD vial: 5 mg, 10 mg
Zorbtive	MD vial: 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

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted from CP.PHAR.55 Somatropin (Human Growth Hormone) policy.	11.21.19	1.7.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q2021 annual review and Changes – policy updated from CP.PHAR.517 Human Growth Hormone(Somapacitan, Somatropin); updated to redirect to Genotropin; added Growth Hormone Deficiency with Neonatal Hypoglycemia (off-label), Growth Hormone Deficiency with Short Stature/Growth Failure - Children *(open epiphyses)*, Genetic Disorders with Short Stature/Growth Failure – Children, Chronic Kidney Disease with Growth Failure – Children, Born Small for Gestational Age with Short Stature/Growth Failure – Children, Growth Hormone Deficiency - Adults and Transition Patients *(closed epiphyses)*, Short Bowel Syndrome – Adults, HIV-Associated Wasting/Cachexia - Adults	4.22.21	
2Q2022 Annual review: added *Appendix B: Therapeutic Alternatives;* Sogroya added new 5 mg/1.5 mL formulation; references reviewed and updated.	6.28.22	
2Q 2023 Annual review: 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; references reviewed and updated; Template changes applied to other diagnoses/indications and continued therapy section.	6.22.23	

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.