



Preferred Specialty Management Growth Hormone

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Product Identifier(s)

15504, 79819

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

National Formulary Medical Necessity

Drugs Affected:

- Genotropin® (somatropin injection)
- Humatrope® (somatropin injection)
- Norditropin® (somatropin injection)
- Nutropin AQ® Nuspin (somatropin injection)
- Omnitrope® (somatropin injection)
- Saizen® (somatropin injection)
- Zomacton™ (somatropin injection)

This Preferred Specialty Management program has been developed to encourage the use of Preferred Products. For all medications (Preferred and Non-Preferred), the individual is required to meet the respective standard *Prior Authorization Policy* criteria. The program also directs the individual to try the Preferred Product(s) prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). All approvals are provided for the durations noted in the respective standard *Prior Authorization Policy* criteria. If the individual meets the standard *Prior Authorization Policy* criteria but has not tried the Preferred Products, approval for the Preferred Product(s) will be authorized. All reviews will be directed to a clinician (i.e., pharmacist) for verification of criteria.

Preferred Products: Genotropin, Norditropin

Non-Preferred Products: Humatrope, Nutropin AQ, Omnitrope, Saizen, Zomacton

Cigna covers growth hormone agents Humatrope, Nutropin AQ, Omnitrope, Saizen, or Zomacton as medically necessary when the following criteria are met:

Criteria

Non-Preferred Product	Exception Criteria
Genotropin	1. Approve if the individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria.
Humatrope	1. Approve if the individual meets the following criteria (i <u>and</u> ii): i. Individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria; AND ii. Individual has tried both of the following products: Genotropin and Norditropin. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has <u>not</u> tried both of the Preferred Products, approve Genotropin and Norditropin. 2. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has not tried both of the Preferred Products, approve Genotropin and Norditropin.
Norditropin	1. Approve if the individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria.
Nutropin AQ	1. Approve if the individual meets the following criteria (i <u>and</u> ii): i. Individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria; AND ii. Individual has tried both of the following products: Genotropin and Norditropin. 2. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has <u>not</u> tried both of the Preferred Products, approve Genotropin and Norditropin.
Omnitrope	1. Approve if the individual meets the following criteria (i <u>and</u> ii): i. Individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria; AND ii. Individual has tried both of the following products: Genotropin and Norditropin. 2. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has <u>not</u> tried both of the Preferred Products, approve Genotropin and Norditropin.
Saizen	1. Approve if the individual meets the following criteria (i <u>and</u> ii): i. Individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria; AND ii. Individual has tried both of the following products: Genotropin and Norditropin.

	<ol style="list-style-type: none"> 2. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has <u>not</u> tried both of the Preferred Products, approve Genotropin and Norditropin.
Zomacton	<ol style="list-style-type: none"> 1. Approve if the individual meets the following criteria (i <u>and</u> ii): <ol style="list-style-type: none"> i. Individual meets the <i>Growth Hormone Prior Authorization Policy</i> criteria; AND ii. Individual has tried both of the following products: Genotropin and Norditropin. 2. If the individual has met the <i>Growth Hormone Prior Authorization Policy</i> Criteria (1Ai), but the individual has <u>not</u> tried both of the Preferred Products, approve Genotropin and Norditropin.

Conditions Not Covered

Any other exception is considered not medically necessary.

Background

Overview

Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, and Zomacton are growth hormone (somatropin) products.¹⁻⁸

References

1. Genotropin® for injection [prescribing information]. New York, NY: Pfizer; April 2019.
2. Humatrope® for injection [prescribing information]. Indianapolis, IN: Eli Lilly and Company; October 2019.
3. Norditropin® injection [prescribing information]. Plainsboro, NJ: Novo Nordisk Inc.; March 2020.
4. Nutropin AQ® Nuspin injection [prescribing information]. South San Francisco, CA: Genentech, Inc.; December 2016.
5. Omnitrope® for injection [prescribing information]. Princeton, NJ: Sandoz Inc; June 2019.
6. Saizen® for injection [prescribing information]. Rockland, MA: EMD Serono Inc; February 2020.
7. Zomacton™ for injection [prescribing information]. Parsippany, NJ: Ferring Pharmaceuticals Inc.; July 2018.

Revision History

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	10/21/2020

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