



PRIOR AUTHORIZATION POLICY

- POLICY:** Growth Disorders – Growth Hormone Prior Authorization Policy
- Genotropin® (somatropin subcutaneous injection – Pfizer)
 - Humatrope® (somatropin subcutaneous injection – Eli Lilly)
 - Norditropin® (somatropin subcutaneous injection – Novo Nordisk)
 - Nutropin AQ® (somatropin subcutaneous injection – Genentech)
 - Omnitrope® (somatropin subcutaneous injection – Sandoz)
 - Saizen® (somatropin subcutaneous injection – EMD Serono)
 - Serostim® (somatropin subcutaneous injection – EMD Serono)
 - Zomacton™ (somatropin subcutaneous injection – Ferring)
 - Zorbtive® (somatropin injection – EMD Serono) [discontinued]

REVIEW DATE: 04/05/2023; selected revision 11/01/2023 (Effective for 1/1/2024)

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.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Indications for somatropin vary among these products. Somatropin is indicated for the following uses:

- **Growth hormone deficiency (GHD) or failure**, treatment of pediatric patients, due to an inadequate secretion of endogenous growth hormone.¹⁻⁷
- **Non-growth hormone deficient short stature (idiopathic short stature)**, treatment, defined by height standard deviation score (SDS) ≤ -2.25 , and associated with growth rates unlikely to permit attainment of adult height in the normal range.^{1-4,6,7}
- **Adults with GHD** for replacement of endogenous growth hormone.¹⁻⁷
- **Children with chronic kidney disease**, treatment of growth failure, up to the time of kidney transplantation.⁴
- **Noonan syndrome**, treatment of patients with short stature.³

- **Prader Willi syndrome**, treatment of patients with growth failure or short stature.^{1,3,7}
- **Short stature homeobox-containing gene (SHOX) deficiency**, treatment of short stature or growth failure in children.^{2,6}
- **Small for gestational age (SGA)**, treatment of growth failure or short stature in patients with no catch-up growth by age 2^{1,7} to 4 years^{2,3,6}
- **Turner syndrome**, treatment of short stature.^{1-4,6,7}
- **Short bowel syndrome**, treatment, in adults receiving specialized nutritional support.⁸
- **Human immunodeficiency virus (HIV)-infected patients with wasting or cachexia**, treatment, to increase lean body mass and body weight, and improve physical endurance.⁹

Growth Hormone Deficiency (GHD) in Children and Adolescents

Somatropin is indicated for the treatment of growth failure in children due to an inadequate secretion of endogenous growth hormone.¹⁻⁷ In these children with GHD, somatropin is effective for increasing final adult height.³¹ Somatropin therapy is recommended to normalize adult height and avoid extreme shortness in children and adolescents with GHD.³¹ Cranial radiation often causes hypopituitarism, and GHD is a frequent pituitary abnormality seen in children and adults who have undergone cranial radiation.¹⁷ Children who have undergone total body irradiation in preparation for hematopoietic stem cell transplant commonly have GHD and an impaired growth rate; these patients can be treated successfully with growth hormone. Somatropin therapy improves the final height of young children after total body irradiation.¹¹

Congenital Hypopituitarism

Somatropin is used in infants and young children with congenital hypopituitarism, that manifests in infancy with hypoglycemia, microgenitalia, hyperbilirubinemia, and multiple anterior pituitary hormone deficiencies.³¹ The Pediatric Endocrine Society guidelines suggest that GHD due to congenital hypopituitarism be diagnosed without formal growth hormone provocative testing in a newborn with hypoglycemia who does not attain a serum growth hormone concentration > 5 mcg/L (> 5 ng/mL) and has deficiency of at least one additional pituitary hormone and/or the classical imaging triad (ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk).³¹

Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in Children or Adolescents

Somatropin is indicated for the long-term treatment of idiopathic short stature (non-growth hormone deficient short stature) which is defined by a height standard deviation score (SDS) ≤ -2.25 , and associated with growth rates that are unlikely to permit attainment of adult height in the normal range.^{1-4,6,7} The predicted adult heights of these children are < 160 cm (63 inches) for men and < 150 cm (59 inches) in women.³¹ The Pediatric Endocrine Society guidelines (2016) recommend that the decision to treat idiopathic short stature with somatropin be made on a case-by-case basis after assessing physical and psychological burdens, and discussion of risks and benefits.³¹ They recommend against the routine use of somatropin in every child with height SDS ≤ -2.25 . In one consensus statement on children with idiopathic

short stature from the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop (2008), it was felt that the optimal age for initiating treatment is 5 years to early puberty.¹²

The initial 6-month trial of somatropin is to establish that the child's condition responds to somatropin therapy. Authorization for continued therapy should be based on an adequate clinical response defined as an annualized growth rate that doubles in comparison to the previous year.¹⁴ Children who show a striking increase in growth velocity during the first 6 to 12 months of somatropin therapy are most likely to benefit from long-term therapy, and therapy should be discontinued if there is no significant increase in growth rate during the first year. Children who have a significant increase in growth rate after the first 6-month trial and the next 12 months should then be reviewed annually for growth rate, closure of the epiphyses, and/or attainment of mid-parental height.

Growth Hormone Deficiency (GHD) in Adults or Transition Adolescents

Somatropin is indicated for the replacement of endogenous growth hormone in adults with GHD, which may present in adults or children as GHD (isolated GHD) or in addition to other pituitary hormone deficiencies (gonadotropin, adrenocorticotrophic hormone, and/or thyroid-stimulating hormone deficiencies).¹⁵ Patients with other anterior pituitary hormone deficiencies are likely to have GHD. In adults, the diagnosis of GHD usually is made in patients with signs and symptoms of hypothalamic-pituitary disease (endocrine, structural, and/or genetic causes); those who have received cranial irradiation or tumor treatment; or those with traumatic brain injury or subarachnoid hemorrhage.^{15,16} Onset may be in adulthood or childhood. In childhood, the goal of somatropin therapy is primarily for statural growth. When final adult height is attained, somatropin therapy is no longer required for statural growth. Transition is used to describe the period in adolescence after growth is completed and the need for continued replacement into adulthood is assessed. Ongoing GHD is most likely in patients with multiple pituitary hormone deficits, with or without structural pituitary or peripituitary disease, and/or a history of cranial radiation therapy. Confirmatory growth hormone stimulation testing may not be required in patients, such as with congenital/genetic GHD or multiple pituitary hormone deficiencies. When persistent GHD is documented after completion of adult height, somatropin therapy should be continued to attain full skeletal and muscle maturation during the transition period from childhood to adulthood.¹⁵ In adults with GHD, somatropin replacement therapy improves abnormalities in substrate metabolism, body composition, and physical and psychosocial function.^{15,16}

Growth hormone is not approved by the FDA for the treatment of other conditions in adults who may have a low growth hormone response to growth hormone provocative testing (such as obesity, aging, or depression) or to improve athletic performance.^{17,18}

Growth Hormone Stimulation Tests (Adults or Transition Adolescents)

The insulin tolerance test is the gold standard growth hormone stimulation test⁵³ but is contraindicated in patients with ischemic heart disease or seizure disorders or in

elderly or pregnant patients.^{15,16,27} The glucagon stimulation test and the macimorelin test could be considered as alternatives.⁵³ The response to all growth hormone stimulation tests show intra-individual variability, and the growth hormone cutoff points vary with the test used. Otherwise healthy obese persons have blunted growth hormone responses to various tests.³⁰ There is no information on the effects of increased body mass index (BMI) or central adiposity on the insulin tolerance test. When Geref (growth hormone releasing hormone) was available [discontinued in the US in 2008], Geref plus arginine was considered the best alternative to the insulin tolerance test in adults.

Macrilen (macimorelin oral solution) is the most recently approved test for the diagnosis of adult GHD. Patients in the pivotal trial were 18 to 66 years of age and the BMI ranged from 16 to 40 kg/m².²⁹ Safety and diagnostic performance have not been established in patients with BMI > 40 kg/m². Clinical studies established that a maximally stimulated serum growth hormone level of < 2.8 ng/mL (i.e., at the 30, 45, 60, and 90 minute time points) after Macrilen administration confirms the presence of adult GHD.

Arginine and levodopa testing have not been systematically evaluated and validated, and because they have a low sensitivity and specificity in adults and transition patients, it is not recommended to utilize these tests in this population.⁵³ Additionally, the clonidine, levodopa, and arginine alone tests are generally not recommended because very low growth hormone cutoff points are required to achieve adequate specificity.²⁷

Adults with childhood onset GHD may have alterations in body composition, bone mineral density, and lipid metabolism that are alleviated by treatment with somatropin.^{15,31} However, some children with a diagnosis of GHD have a normal somatotrophic axis when retested in late adolescence.^{31,52} Re-evaluation of the somatotrophic axis in children diagnosed with GHD is required during the transition period. The transition period is the time from late puberty to establishment of adult muscle and bone composition, and encompasses attainment of adult height.³¹ Re-evaluation of the somatotrophic axis is most conveniently done when growth has slowed to the point where pediatric somatropin dosing will be discontinued (i.e., the growth velocity is < 2 to 2.5 cm/year). Recommendations for transitional care after childhood somatropin treatment from the Pediatric Endocrine Society guidelines³¹ are as follows: Patients with multiple (≥ 3) pituitary hormone deficiencies regardless of etiology, or GHD with a documented causal genetic mutation or specific pituitary/hypothalamic structural defect (except ectopic posterior pituitary) be diagnosed with persistent GHD. These guidelines recommend re-evaluation of the somatotrophic axis for persistent GHD in persons with 1) GHD and deficiency of only one additional pituitary hormone, 2) idiopathic isolated GHD, 3) idiopathic isolated GHD with or without a small pituitary/ectopic posterior pituitary, and 4) in patients after irradiation. Testing can be done after a trial of at least 1 month off somatropin treatment. The guidelines also recommend growth hormone provocative testing to evaluate the function of the somatotrophic axis in the transition period if indicated by a low insulin-like growth factor (IGF)-1 level. Persons with idiopathic isolated GHD will very likely test sufficient with growth hormone provocative testing. To continue

growth hormone therapy in adulthood, retesting for GHD with growth hormone stimulation test(s) is recommended in most transition patients and at least 1 month after discontinuation of pediatric growth hormone therapy.⁵³ Retesting is not required in transition patients with evidence of panhypopituitarism (≥ 3 pituitary hormone deficiencies) and low serum IGF-1 levels, patients with genetic defects, and patients with hypothalamic-pituitary structural brain defects.

Adult GHD can be predicted with $> 90\%$ accuracy by the presence of three or four pituitary hormone deficiencies in addition to serum IGF-1 concentration that is less than the 2.5 percentile or < -2 SDS.^{15,16} This is in the absence of conditions that lower IGF-1. Patients with ≥ 3 pituitary hormone deficiencies and an IGF-1 level below the reference range do not need a growth hormone stimulation test.¹⁶ Because of the nature of the cause of GHD in children with structural lesions with multiple hormone deficiencies and those with proven genetic causes, provocative testing in these adults is not necessary.

Chronic Kidney Disease in Children or Adolescents

Somatropin is indicated for the treatment of growth failure in children with chronic kidney disease up to the time of kidney transplantation and is effective for increasing the rate of growth.⁴ Somatropin therapy has increased final adult height in these patients.¹⁹ An adequate growth response can be assumed if height velocity during the first year of growth hormone treatment is greater than 2 cm per year over baseline.²⁰ This increase is supported by outcomes of controlled trials specific to patients with chronic kidney disease. Guidelines recommend that persistent growth failure (defined as height below the third percentile and height velocity below the 25th percentile beyond a period of 3 months in infants or 6 months in children and adolescents), be an indication for growth hormone therapy once other potentially treatable risk factors for growth failure have been adequately addressed.²⁰ Growth hormone therapy can be initiated 1 year after transplantation if spontaneous catch-up growth does not occur and steroid-free immunosuppression is not a feasible option.

Noonan Syndrome and Short Stature in Children or Adolescents

Somatropin is indicated for the treatment of children with short stature associated with Noonan syndrome.^{3,21} Not all patients with Noonan syndrome have short stature; some will achieve a normal adult height without treatment. The younger the age at start of therapy, the larger the change in height SDS.

Prader-Willi Syndrome

Somatropin is indicated for the treatment of pediatric patients who have growth failure due to Prader-Willi syndrome.^{1,3,7} Somatropin therapy in children increases linear growth velocity, improves body composition (i.e., decreases the percentage body fat, increases or stabilizes lean body mass), increases bone mineral density, improves physical strength and agility, and improves final adult height.²² After final height is attained, there may be potential benefits of somatropin on body composition, peak bone mass, cognition, and quality of life in adults.²² Somatropin is contraindicated in patients with Prader-Willi syndrome who are severely obese or

have severe respiratory impairment.^{1,3,7} Confirmation of Prader-Willi requires molecular genetic testing for the identification of Prader-Willi genetic subtypes.⁵⁴

Short Stature Homeobox-Containing Gene (SHOX) Deficiency in Children or Adolescents

Somatropin is indicated for the treatment of short stature or growth failure in children with SHOX deficiency.^{2,6} SHOX deficiency may result from either deletion of one copy of the *SHOX* gene or from mutation within or outside one copy of the *SHOX* gene that impairs the production or function of the SHOX protein. Women with Turner syndrome have only a single copy of the SHOX gene because they lack all or part of their second X chromosome.²³ SHOX deficiency is also the primary cause of short stature in most patients with Léri-Weill dyschondrosteosis (syndrome), and *SHOX* mutations and deletions are found in patients with idiopathic short stature. In one study consisting of a 2-year control period and a subsequent extension period to final height, short prepubertal patients with SHOX deficiency received somatropin.²⁴

Children Born Small for Gestational Age (SGA)

Somatropin is indicated for the treatment of growth failure in children born SGA who fail to exhibit catch-up growth by age 2^{1,7} to 4 years.^{2,3,6} SGA is defined as a birth weight and/or birth length that is greater than 2 standard deviation (SD) [about the 3rd percentile] below mean normal values after adjusting for gestational age and sex. The terms SGA and intrauterine growth restriction are used interchangeably in this document. In clinical trials, patients born SGA (including children with Silver-Russell syndrome) without catch-up growth who were 2 to 11 years of age had significant increases in growth when treated with somatropin before puberty.^{1,3} Optimal duration of therapy once catch-up growth has been attained is not known.

Almost all patients with Silver-Russell syndrome are born SGA, and postnatal catch-up growth does not occur in the majority of children.⁴⁴ An expert consensus statement recommends that patients with Silver-Russell syndrome receive treatment with somatropin as soon as possible.⁴⁴ Starting therapy at age 2 to 4 years is adequate for the majority of patients. In some cases, somatropin therapy is started in patients less than 2 years of age who have severe fasting hypoglycemia, severe malnutrition, or severe muscular hypotonia. These experts recommend that somatropin therapy be stopped when height velocity is < 2 cm per year over a 6-month period and when bone age is > 14 years in females or > 17 years in males.

Turner Syndrome

Somatropin is indicated for the treatment of short stature associated with Turner syndrome.^{1-4,6,7} Turner syndrome is a sex chromosome disorder caused by loss of part or all of an X chromosome; the diagnosis is confirmed by karyotype analysis. Growth hormone therapy is used to maximize adult height in these patients; there is no physiological rationale for continuing growth hormone into the transition period after the completion of puberty.²⁵

Short Bowel Syndrome

Somatropin is indicated for the treatment of short bowel syndrome in adults receiving specialized nutritional support.¹¹

Human Immunodeficiency Virus-Associated Wasting or Cachexia

Somatropin is indicated for the treatment of HIV-infected adults with wasting (loss of lean body mass) or cachexia to increase lean body mass and body weight, and improve physical endurance.⁹ Somatropin therapy increases lean body mass, decreases fat mass, and increases physical function in patients with HIV-associated wasting. Studies directly comparing somatropin with other therapies (megestrol, oxandrolone, testosterone, and progressive resistance training) for wasting or cachexia in HIV-infection are lacking.²⁶

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of somatropin. All reviews will be directed to a clinician (i.e., pharmacist) for verification of criteria. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with somatropin as well as the monitoring required for adverse events and long-term efficacy, approval for some indications requires somatropin to be evaluated by a physician who specializes in the condition being treated. Human growth hormone is FDA-approved for treatment of a limited number of conditions. The FDA has not approved the use of human growth hormone as therapy for anti-aging, longevity, cosmetic uses, or performance enhancement. Federal law prohibits the dispensing of human growth hormone for non-approved purposes. A pharmacy's failure to comply with that law could result in significant criminal penalties to the pharmacy and its employees. Accordingly, a pharmacy may decline to dispense prescriptions for human growth hormone when written by physicians or other authorized prescribers who they believe may be involved in or affiliated with the fields of anti-aging, longevity, rejuvenation, cosmetic uses, performance enhancement, or sports medicine.

Documentation: Documentation is required for use of somatropin as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. For patient cases in which documentation is required, if this documentation has been previously received upon a prior coverage review, the documentation requirement is considered to be met.

- **Genotropin (somatropin subcutaneous injection – Pfizer)**
- **Humatrope (somatropin subcutaneous injection – Eli Lilly)**
- **Norditropin® (somatropin subcutaneous injection – Novo Nordisk)**
- **Nutropin AQ (somatropin subcutaneous injection – Genentech)**
- **Omnitrope® (somatropin subcutaneous injection – Sandoz)**
- **Saizen® (somatropin subcutaneous injection – EMD Serono)**
- **Serostim (somatropin subcutaneous injection – EMD Serono)**
- **Zomacton™ (somatropin subcutaneous injection – Ferring)**
- **Zorbtive (somatropin injection – EMD Serono) [discontinued]**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

- I.** Coverage of Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, and Zomacton (all listed products except Serostim and Zorbtive) is recommended in those who meet at least ONE of the following criteria:

FDA-Approved Indications

- 1. Growth Hormone Deficiency in a Child or Adolescent.** Approve for 1 year if the patient meets ONE of the following (A or B):

A) Initial therapy. Approve if the patient meets at least ONE of the following (i, ii, iii, iv, or v):

- i.** Patient meets BOTH of the following (a and b):

a) Patient meets at least ONE of the following (1 or 2):

(1) Patient has had two growth hormone stimulation tests performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the peak growth hormone response to both tests are < 10 ng/mL; OR

(2) Patient meets BOTH of the following (i and ii):

(i) Patient has had at least one growth hormone stimulation test performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the peak growth hormone response to at least one test is < 10 ng/mL; AND

(ii) Patient has at least one risk factor for growth hormone deficiency; AND

Note: Examples of at least one risk factor for growth hormone deficiency includes: the height for age curve has deviated downward across two major height percentiles [e.g., from above the 25th percentile to below the 10th percentile]; patient's growth rate is less than the expected normal growth rate based on age and gender; patient has low insulin-like growth factor (IGF)-1 and/or IGF binding protein-3 levels; patient has a very low peak growth hormone level on provocative testing as defined by the prescribing physician; patient's growth velocity is less than the 10th percentile for age and gender [height velocity percentile is NOT the same as height-for-age percentile]; patient is status post craniopharyngioma resection; patient has optic nerve hypoplasia; patient has a growth hormone gene deletion.

Note: Some patients will achieve stimulated growth hormone concentrations in the normal range as determined by the testing laboratory and could be reviewed for authorization under non-growth hormone deficiency short stature (idiopathic short stature); AND

b) Patient has been evaluated by an endocrinologist; OR

- ii. Patient has undergone brain radiation or tumor resection AND meets BOTH of the following (a and b):
 - a) Patient meets at least ONE of the following (1 or 2):
 - (1) Patient meets BOTH of the following (i and ii):
 - (i) Patient has had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND
 - (ii) The peak growth hormone response to at least one test is < 10 ng/mL; OR
 - (2) Patient has a deficiency in at least one other pituitary hormone (i.e., adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin deficiency [luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency], or prolactin); AND
 - b) Patient has been evaluated by an endocrinologist; OR
- iii. Patient has congenital hypopituitarism AND meets BOTH of the following (a and b):
 - a) Patient meets at least ONE of the following (1, 2, or 3):
 - (1) Patient meets BOTH of the following (i and ii):
 - (i) Patient has had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND
 - (ii) The peak growth hormone response to at least one test is < 10 ng/mL; OR
 - (2) Patient has a deficiency in at least one other pituitary hormone (i.e., adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin deficiency [luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency], or prolactin); OR
 - (3) Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk; AND
 - b) Patient has been evaluated by an endocrinologist; OR
- iv. Patient has multiple pituitary hormone deficiencies and meets BOTH of the following (a and b):

Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency.

 - a) Patient meets at least ONE of the following (1 or 2):
 - (1) Patient has three or more of the following pituitary hormone deficiencies: somatotropin (growth hormone), adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin deficiency (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and prolactin; OR
 - (2) Patient meets BOTH of the following (i and ii):
 - (i) Patient has had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND

- (ii) The peak growth hormone response to at least one test is < 10 ng/mL; AND
 - b)** Patient has been evaluated by an endocrinologist; OR
 - v.** Patient has had a hypophysectomy (surgical removal of pituitary gland).
 - B) Patient is continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months).** Approve if the patient meets at least ONE of the following (i, ii, or iii):
 - i.** Patient is < 12 years of age. Patient's height has increased by ≥ 2 cm/year in the most recent year; OR
 - ii.** Patient is between ≥ 12 years and < 18 years of age. Patient meets BOTH of the following (a and b):
 - a)** Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - b)** Patient's epiphyses are open; OR
 - iii.** Patient is ≥ 18 years of age. Patient meets ALL of the following (a, b, and c):
 - a)** Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - b)** Patient's epiphyses are open; AND
 - c)** Patient's mid-parental height has not been attained.
- Note: Mid-parental height is the father's height plus the mother's height divided by 2, plus 2.5 inches if male or minus 2.5 inches if female.
- Note: Adolescents and young adults with childhood onset growth hormone deficiency who have previously responded to somatropin with increases in height velocity and who have completed linear growth may continue receiving somatropin therapy as a transition adolescent or as an adult. See criteria I.3. (Growth hormone deficiency in an adult or transition adolescent).

2. Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent. Approve for the duration noted if the patient meets at least ONE of the following (A or B):

- A) Initial therapy.** Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
 - i.** Patient is ≥ 5 years of age; AND
 - ii.** Patient's baseline height is ≤ 1.2 percentile or a standard deviation score (SDS) ≤ -2.25 for age and gender; AND
 - iii.** Patient's growth (height) velocity meets at least ONE of the following (a or b):
 - a)** Patient has a growth rate < 4 cm/year; OR
 - b)** Patient's growth (height) velocity is less than the 10th percentile for age and gender based on at least 6 months of growth data; AND
- Note: Height velocity percentile is NOT the same as height for age percentile.
- iv.** Without growth hormone therapy, the patient's predicted adult height is < 160 cm (63 inches) in males or < 150 cm (59 inches) in females; AND
- v.** Patient's epiphyses are open; AND
- vi.** Patient does not have constitutional delay of growth and puberty.

B) Patient is continuing somatropin therapy. Approve for 1 year if the patient meets at least ONE of the following (i or ii):

i. Patient has received somatropin for ≥ 6 months and < 10 months. Approve if the patient meets BOTH of the following (a and b):

a) Patient is ≥ 5 years of age; AND

b) Patient's annualized growth rate has doubled in comparison to the previous year; OR

Note: For example, if the growth velocity was 3 cm/year for the year prior to treatment, then the growth velocity must be at least 3 cm in 6 months (baseline velocity was 1.5 cm/6 months) or for example, the growth velocity was 2 cm/year for the year prior to treatment, then after 6 months of somatropin therapy, the growth velocity must be at least 2 cm in 6 months (1 cm/6 months baseline).

ii. Patient has received somatropin for ≥ 10 months. Approve if the patient meets at least ONE of the following (a, b, or c):

a) Patient is ≥ 5 years and < 12 years of age. Patient's height has increased by ≥ 2 cm/year in the most recent year; OR

b) Patient is ≥ 12 years of age and < 18 years of age. Patient meets BOTH of the following (1 and 2):

(1) Patient's height has increased by ≥ 2 cm/year in the most recent year; AND

(2) Patient's epiphyses are open; OR

c) Patient is ≥ 18 years of age. Patient meets ALL of the following (1, 2, and 3):

(1) Patient's height has increased by ≥ 2 cm/year in the most recent year; AND

(2) Patient's epiphyses are open; AND

(3) Patient's mid-parental height has not been attained.

Note: Mid-parental height is the father's height plus the mother's height divided by 2, plus 2.5 inches if male or minus 2.5 inches if female.

3. Growth Hormone Deficiency in an Adult or Transition Adolescent. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):

A) The endocrinologist must certify that somatropin is not being prescribed for anti-aging therapy or to enhance athletic ability or for body building; AND

B) Patient must have a diagnosis of growth hormone deficiency that is ONE of the following (i or ii): **[documentation required for all elements]**

i. Childhood onset; OR

ii. Adult onset that results from one of the following: growth hormone deficiency alone or multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease, hypothalamic disease, pituitary surgery, cranial radiation therapy, tumor treatment, traumatic brain injury, or subarachnoid hemorrhage; AND

C) Patient meets at least ONE of the following (i, ii, or iii):

i. Patient (adult or transition adolescent) has known perinatal insults OR congenital or genetic defects; **[documentation required] OR**

ii. Patient meets ALL of the following (a, b, and c):

- a) Patient (adult onset or transition adolescent) has three or more of the following pituitary hormone deficiencies: Adrenocorticotrophic hormone , thyroid-stimulation hormone, gonadotropin deficiency (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and prolactin **[documentation required]**; AND
 - b) The age and gender adjusted serum insulin-like growth factor-1 is below the lower limit of the normal reference range for the reporting laboratory **[documentation required]**; AND
 - c) Other causes of low serum insulin-like growth factor-1 have been excluded (e.g., malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy); OR
- iii. Patient meets at least ONE of the following (a or b):
- a) Adult. Patient has had a negative response to at least ONE of the following standard growth hormone stimulation tests (1, 2, 3, 4, 5, or 6) **[documentation required for all elements]**:
Note: If the patient has had a previous trial of an arginine test with a peak response of ≤ 0.4 mcg/L, this would meet the criteria for a negative response to a growth hormone stimulation test.
 - (1) Insulin tolerance test (obtaining at least 3 growth hormone levels in at least a 60 minute timeframe [not including a level at timeframe zero], with adequate hypoglycemia being achieved) with peak response ≤ 5.0 mcg/L; OR
 - (2) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response ≤ 3.0 mcg/L AND the patient's body mass index (BMI) is < 25 kg/m²; OR
 - (3) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response ≤ 3.0 mcg/L AND the patient's BMI is ≥ 25 kg/m² and ≤ 30 kg/m² with, according to the prescriber, a high pretest probability of growth hormone deficiency; OR
 - (4) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response ≤ 1.0 mcg/L AND the patient's BMI is ≥ 25 kg/m² and ≤ 30 kg/m² with, according to the prescriber, a low pretest probability of growth hormone deficiency; OR
 - (5) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response ≤ 1.0 mcg/L AND the patient's BMI is > 30 kg/m²; OR
 - (6) Macrilen (macimorelin oral solution) test (obtaining at least 4 growth hormone levels in at least a 90 minute timeframe [not including a level at timeframe zero]) with peak responses < 2.8 ng/mL (2.8 mcg/L) AND the patient's BMI is ≤ 40 kg/m².

Note: The following formula can be used to calculate BMI: BMI equals body weight in kg divided by height meters squared (m^2) [i.e., BMI = kg/m^2]; OR

- b) Transition adolescent.** Patient meets BOTH of the following (1 and 2):
[documentation required for all elements]:

Note: The transition period is the time from late puberty to establishment of adult muscle and bone composition, and encompasses attainment of adult height.

Note: If the patient has had a trial of a Macrilen test with a peak response of < 2.8 ng/mL (mcg/L), this would meet the criteria for a negative response to a growth hormone stimulation test.

(1) Patient has been off somatropin therapy for at least 1 month before retesting with a growth hormone stimulation test; AND

(2) Patient meets at least ONE of the following responses to growth hormone stimulation testing (i, ii, iii, iv, v or vi):

(i) Insulin tolerance test (obtaining at least 3 growth hormone levels in at least a 60 minute timeframe [not including a level at timeframe zero], with adequate hypoglycemia being achieved) with peak response ≤ 5.0 mcg/L; OR

(ii) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response ≤ 3.0 mcg/L AND the patient's body mass index (BMI) is < 25 kg/m^2 ; OR

(iii) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response of ≤ 3.0 mcg/L AND the patient's BMI is ≥ 25 kg/m^2 and ≤ 30 kg/m^2 with, according to the prescriber, a high pretest probability of growth hormone deficiency; OR

(iv) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response ≤ 1.0 mcg/L AND the patient's BMI is ≥ 25 kg/m^2 and ≤ 30 kg/m^2 with, according to the prescriber, a low pretest probability of growth hormone deficiency; OR

(v) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response ≤ 1.0 mcg/L AND the patient's BMI is > 30 kg/m^2 ; OR

(vi) If both the insulin tolerance test AND glucagon stimulation test are contraindicated, the arginine test can be used (obtaining at least 3 growth hormone levels in at least 120 minute timeframe [not including a level at timeframe zero]) with a peak response ≤ 0.4 mcg/L; AND

D) Patient has been evaluated by an endocrinologist.

4. Chronic Kidney Disease in a Child or Adolescent. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A)** Patient has or had chronic kidney disease as defined by a glomerular filtration rate < 60 milliliters/minute; AND
- B)** Patient meets at least ONE of the following (i or ii):
 - i.** Initial therapy. Approve if the patient meets BOTH of the following (a and b):
 - a)** Patient has persistent growth failure as defined as BOTH of the following (1 and 2):
 - (1)** Patient's baseline height is less than the 5th percentile for age and gender; AND
 - (2)** Patient's baseline height velocity is below the 25th percentile over a period of 3 months in infants (\leq 1 year of age) or 6 months in children and adolescents; AND
 - b)** Patient has been evaluated by an endocrinologist or a nephrologist; OR
 - ii.** Patient is continuing somatropin therapy (i.e., established on somatropin for \geq 10 months). Approve if the patient meets BOTH of the following (a and b):
 - a)** Patient's height has increased by \geq 2 cm/year in the most recent year; AND
 - b)** Patient's epiphyses are open.

5. Noonan Syndrome in a Child or Adolescent. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A)** The diagnosis of Noonan syndrome has been confirmed by ONE of the following (i or ii):
 - i.** Noonan syndrome has been confirmed with genetic testing; OR
 - ii.** If genetic testing does not definitively confirm the diagnosis, the prescriber has made a clinical diagnosis of Noonan syndrome: AND
Note: Clinical diagnosis includes abnormal facial features (high forehead, epicanthic folds, etc.), pulmonary valve stenosis and/or hypertrophic cardiomyopathy, first-degree relative with Noonan syndrome, mild developmental delay.
- B)** Patient meets at least ONE of the following (i or ii):
 - i.** Initial therapy. Approve if the patient meets BOTH of the following (a and b):
 - a)** Patient's baseline height is less than the 5th percentile using a growth chart for children without Noonan syndrome; AND
 - b)** Patient has been evaluated by an endocrinologist; OR
 - ii.** Patient is continuing somatropin therapy (i.e., established on somatropin for \geq 10 months). Approve if the patient meets BOTH of the following (a and b):
 - a)** Patient's height has increased by \geq 2 cm/year in the most recent year; AND
 - b)** Patient's epiphyses are open.

6. Prader-Willi Syndrome. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A)** The diagnosis of Prader-Willi syndrome has been confirmed by genetic testing; AND

- B)** Patient meets at least ONE of the following (i or ii):
- i.** Initial therapy. Approve if the patient (child or adult) has been evaluated by an endocrinologist; OR
 - ii.** Patient is continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). Approve if the patient meets at least ONE of the following (a or b):
 - a)** Child or adolescent. The patient meets BOTH of the following (1 and 2):
 - (1)** Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - (2)** Patient's epiphyses are open; OR

Note: When the epiphyses are closed and/or the height velocity is < 2 cm/year, the patient can be reviewed for continuation of therapy as an adult with Prader-Willi syndrome.
 - b)** Adult or adolescent whose epiphyses are closed and/or whose height velocity is < 2 cm/year. Patient meets BOTH of the following (1 and 2):
 - (1)** This physician must certify that somatropin is not being used for anti-aging therapy or to enhance athletic performance/body building; AND
 - (2)** Patient must be evaluated by an endocrinologist or in consultation with an endocrinologist.

7. Short Stature Homeobox-Containing Gene Deficiency in a Child or Adolescent. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A)** Patient has short stature homeobox-containing gene deficiency demonstrated by chromosome analysis; AND
- B)** Patients meets at least ONE of the following (i or ii):
 - i.** Initial therapy. Approve if the patient meets ALL of the following (a, b, and c):
 - a)** Patient's epiphyses are open; AND
 - b)** Patient's baseline height is less than the 5th percentile for age and gender; AND
 - c)** Patient has been evaluated by an endocrinologist;OR
 - ii.** Patient is continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). Approve if the patient meets BOTH of the following (a and b):
 - a)** Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - b)** Patient's epiphyses are open.

8. Child Born Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russell Syndrome. Approve for 1 year if the patient meets BOTH of the following (A and B):

- A)** Patient meets BOTH of the following (i and ii):
 - i.** Patient was born small for gestational age, which is defined as birth weight and/or birth length that is > 2 standard deviations (SD) below the mean (< -2 SD) for gestational age and gender; AND

- ii. Patient did not have sufficient catch-up growth before age 2 to 4 years; AND
 - B)** Patient meets at least ONE of the following (i or ii):
 - i. Initial therapy. Approve if the patient meets ALL of the following (a, b, and c):
 - a) Patient is ≥ 2 years of age; AND
 - b) Patient's baseline height is less than the 5th percentile for age and gender; AND
 - c) Patient has been evaluated by an endocrinologist; OR
 - ii. Patient is continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). Approve if the patient meets at least ONE of the following (a or b):
 - a) Patient is < 12 years of age. Patient's height has increased by ≥ 2 cm/year in the most recent year; OR
 - b) Patient is ≥ 12 years. Patient meets BOTH of the following (1 and 2):
 - (1) Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - (2) Patient's epiphyses are open.
- 9. Turner Syndrome.** Approve for 1 year if the patient meets BOTH of the following (A and B):
- A)** The diagnosis of Turner's syndrome has been confirmed by karyotype analysis (i.e., chromosome analysis); AND
 - B)** Patient meets at least ONE of the following (i or ii):
 - i. Initial therapy. Patient's baseline height is less than the 5th percentile for age and gender; OR
 - ii. Patient is continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). Approve if the patient meets BOTH of the following (a and b):
 - a) Patient's height has increased by ≥ 2 cm/year in the most recent year; AND
 - b) Patient's epiphyses are open.
- II. Coverage of Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Zomacton, and Zorbtive** (all listed products except Serostim) is recommended in patients who meet the following criteria:
- 1. Short Bowel Syndrome in an Adult.** Approve for 1 month if the patient meets at least ONE of the following (A or B):
- A)** Initial therapy. Approve if the patient meets ALL of the following (i, ii, and iii):
 - i. Patient is ≥ 18 years of age; AND
 - ii. Patient is receiving specialized nutritional support (defined as a high carbohydrate, low-fat diet that is adjusted for individual patient requirements and preferences); AND
 - iii. Patient is dependent on intravenous parenteral nutrition.
 - B)** Patient is continuing somatropin therapy. Approve if the adult patient responded to somatropin therapy with a decrease in the requirement for specialized nutritional support according to the prescriber.

III. Coverage of Serostim is recommended in those who meet the following criteria:

1. Human Immunodeficiency Virus Infection with Wasting or Cachexia in an Adult. Approve for 6 months if the patient meets ALL of the following (A, B, C, D, E, F, and G):

A) Patient is ≥ 18 years of age; AND

B) Patient meets at least ONE of the following (i, ii, or iii):

i. Documented unintentional weight loss of $\geq 10\%$ from baseline; OR

ii. Patient's weight $< 90\%$ of the lower limit of ideal body weight; OR

iii. Patient's body mass index (BMI) ≤ 20 kg/m²; AND

Note: The following formula can be used to calculate BMI: BMI equals body weight in kg divided by height in meters squared (m²) [i.e., BMI = kg/m²].

C) Patient has wasting or cachexia that is due to malabsorption, poor diet, opportunistic infection, or depression, and other causes have been addressed prior to starting somatropin; AND

D) Patient has been on antiretroviral therapy or highly active antiretroviral treatment for ≥ 30 days prior to beginning Serostim therapy and will continue antiretroviral therapy throughout the course of Serostim treatment; AND

E) Serostim is not being used solely for treatment of alterations in body fat distribution such as increased abdominal girth, lipodystrophy and excess abdominal fat, or buffalo hump; AND

F) Patient meets at least ONE of the following (i or ii):

i. Patient has tried one appetite stimulant or other anabolic agent; OR

Note: Examples of appetite stimulants or other anabolic agents include megestrol acetate, dronabinol, oxandrolone.

ii. Appetite stimulants or other anabolic agents are contraindicated; AND

G) If the patient has previously received treatment with Serostim for this use, patient has been off Serostim therapy for at least 1 month.

CONDITIONS NOT COVERED

- **Genotropin (somatropin subcutaneous injection – Pfizer)**
- **Humatrope (somatropin subcutaneous injection – Eli Lilly)**
- **Norditropin® (somatropin subcutaneous injection – Novo Nordisk)**
- **Nutropin AQ (somatropin subcutaneous injection – Genentech)**
- **Omnitrope® (somatropin subcutaneous injection – Sandoz)**
- **Saizen® (somatropin subcutaneous injection – EMD Serono)**
- **Serostim (somatropin subcutaneous injection – EMD Serono)**
- **Zomacton™ (somatropin subcutaneous injection – Ferring)**
- **Zorbtive (somatropin injection – EMD Serono) [discontinued]**

is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

Note: For some of the following indications, authorization for coverage is not recommended because the indication is excluded from coverage in a typical pharmacy benefit.

- 1. Acute Critical Illness Due to Complications Following Surgery, Multiple Accidental Trauma, or with Acute Respiratory Failure.**¹⁻⁹ In two placebo-controlled trials in non-growth hormone deficient adults (n = 522) with these conditions, there was a significant increase in mortality (42% vs. 19%) in patients treated with somatropin compared to those on placebo.
- 2. Aging (i.e., Anti-Aging), to Improve Functional Status in an Elderly Patient, and Somatopause.**^{17,18,32,33} Somatropin is not FDA-approved for anti-aging therapy, to improve functional status in elderly patients, or to treat somatopause. Federal law prohibits the distribution or dispensing of somatropin for non-FDA approved uses. There are no long-term studies assessing somatropin efficacy and safety for anti-aging therapy. Short-term therapy with somatropin may improve some measures of body composition, including increased muscle mass, reduced total body fat, improved skin elasticity, and reduced rate of bone demineralization, but somatotropin does not have positive effects on strength, functional capacity, or metabolism. Somatropin is associated with considerable adverse effects in non-growth hormone deficient adults (e.g., carpal tunnel syndrome, soft tissue edema, arthralgias, glucose intolerance, increased serum lipids). Another concern is the possible increased risk of cancer with long-term use of somatropin and the potentiating effects of IGFs on cancer. Somatropin is not indicated for the age-related decrease in growth hormone/IGF-1 status.¹⁶
- 3. Athletic Ability Enhancement.**^{18,34} Somatropin is not FDA-approved for athletic performance enhancement or for body building in nonathletes. Federal law prohibits the distribution or dispensing of somatropin for non-FDA approved uses. Short-term administration of somatropin to increase strength and endurance in athletes is no more effective than training alone and somatropin should not be administered to athletes or other persons for the purpose of enhancing athletic ability or improving personal appearance (i.e., to appear leaner and more muscular). Somatropin has been used in supraphysiologic doses alone or in combination with other performance enhancing drugs (PEDs) in users who are not athletes.³⁴ Use of PEDs has been linked to an increased risk of death and many adverse effects including cardiovascular, psychiatric, metabolic, endocrine, neurologic, infectious, hepatic, renal, and musculoskeletal disorders.
- 4. Central Precocious Puberty.** Children with precocious puberty are often treated with gonadotropin releasing hormone (GnRH) agonists (Lupron® [leuprolide acetate injection]) to suppress pituitary gonadal activity, to slow the advancement of bone age (prevent premature fusion of the epiphyseal growth plates), and to improve adult height. In some patients GnRH agonist therapy may result in marked deceleration of bone growth and may result in adult height that is less than the mid-parental height. Somatropin has been used in girls when growth velocity decreases or if it appears that the targeted adult height will not be attained.³⁵ There are no large well-controlled trials on the efficacy and safety of

adding somatropin to GnRH agonist therapy in these children or the effect on final height.^{35,36}

- 5. Chronic Fatigue Syndrome.** There is no evidence of GHD in chronic fatigue syndrome.³⁷
- 6. Congenital Adrenal Hyperplasia (CAH).**^{38,39} The Endocrine Society clinical practice guidelines on CAH due to steroid 21-hydroxylase deficiency recommend against the use of experimental treatment approaches outside of formally approved clinical trials.³⁹ Children with predicted adult height SD ≤ -2.25 may be considered for growth-promoting treatments in appropriately controlled trials.
- 7. Constitutional Delay of Growth and Puberty.** These children have delayed skeletal maturation and pubertal development. Administering somatropin does not increase adult height (which is usually normal).⁴⁰ Short-term androgen therapy accelerates growth and the rate of pubertal advancement in boys.
- 8. Corticosteroid-Induced Short Stature.**¹³ This includes a variety of chronic glucocorticoid-dependent conditions, such as asthma, Crohn's disease,¹³ juvenile rheumatoid arthritis,^{28,41,42} as well as after renal, heart, liver, or bone marrow transplantation.⁴³ Short-term improvement in growth velocity in children with glucocorticoid-induced suppression has been reported with somatropin therapy. Long-term data are not available.¹³ Children being considered for treatment with somatropin should be enrolled in studies that allow careful monitoring and data analysis.
- 9. Fibromyalgia.** In one placebo-controlled study, 120 non-GHD adult women with severe fibromyalgia and low levels of IGF-1 were randomized to somatropin 0.006 mg/kg/day for 12 months (dose was adjusted) or placebo for 6 months.⁴⁵ Patients receiving placebo initially were switched to somatropin from Months 6 to 12 (open label). Standard therapy for fibromyalgia was continued. After 6 months, there were no differences between somatropin and placebo in the percentage of patients with fewer than 11 positive tender points, mean number of tender points, intensity of pain in every point evaluated, and other measures. After 12 months of somatropin therapy, 53% of patients had less than 11 positive tender points compared with 33% of patients who received placebo and then somatropin for 6 months ($P < 0.05$). At 18 months follow-up evaluation when somatropin was discontinued, impairment in pain perception worsened in both groups but to a lesser extent in the patients on somatropin for 12 months. Further controlled trials with a longer duration,⁴⁶ with different doses, and using the 2010 American College of Rheumatology criteria for fibromyalgia are needed. Some patients with fibromyalgia may have adult GHD.
- 10. Human Immunodeficiency Virus (HIV)-Infected Patient with Alterations in Body Fat Distribution** (e.g., increased abdominal girth, lipodystrophy and excess abdominal fat, buffalo hump).²⁶ Somatropin is not indicated for the treatment of HIV-associated adipose redistribution syndrome (HARS). HARS is a subset of HIV lipodystrophy and is defined as maldistribution of body fat

characterized by central fat accumulation (lipohypertrophy) with or without lipoatrophy. In HARS, fat may also accumulate in the upper body subcutaneous area such as the dorsocervical area (buffalo hump). These changes may be associated with metabolic disturbances (insulin resistance, glucose intolerance, dyslipidemia) and belly image distress. Safety and efficacy are not established.

11. Infertility.^{47,10} Clinical trials indicate that somatropin is not useful as an adjunct during in vitro fertilization, for induction of ovulation in polycystic ovary syndrome, or for assisted reproductive technology. The authors of a recent meta-analysis concluded there is no evidence of an increased chance of a live birth with use of somatropin.

12. Obesity.^{48,49} Somatropin is not indicated for the treatment of obesity. Low growth hormone levels are a consequence of central obesity and not a cause. Obesity is associated with decreased basal and pulsatile release of growth hormone and decreased stimulated growth hormone release. Somatropin therapy does not have significant beneficial effects on obesity in persons without GHD and does not produce significant overall weight loss. Supraphysiologic doses of somatropin have been used to treat obesity. Effects of long-term therapy with somatropin are unknown.

13. Osteoporosis.^{50,51} Guidelines for treatment or prevention of osteoporosis do not include recommendations for use of somatropin. In one double-blind trial, 80 postmenopausal women with osteoporosis (56% of patients [n = 45/80] had a history of fractures) were randomized to somatropin 0.33 mg/day or 0.83 mg/day or to placebo for three years.⁵⁰ The double-blind phase was 18 months and patients on somatropin continued drug for another 18 months and patients on placebo stopped at 18 months. Patients were compared with an age-matched random population sample of women (n = 120). All patients received calcium 750 mg, vitamin D 400 units, and hormone replacement therapy. All women were followed for a total of 10 years. Bone mineral density (BMD) increased in the patients receiving somatropin at Years 4 and 5, and after 10 years, BMD decreased to similar levels as before treatment. At 10 years, 28% of women (n = 22/80) had fractures. In the control group, fractures increased from 8% of patients at baseline to 32% of patients after 10 years. At 10 years, 41% of patients (n = 33/80) had stopped hormone replacement therapy; 23% had started bisphosphonates due to fractures, and 3% had received Forteo® (teriparatide injection). Larger studies are needed to determine the effects of somatropin therapy on bone mineral density and fractures in non-growth hormone deficient persons.

REFERENCES

1. Genotropin® subcutaneous injection [prescribing information]. New York, NY: Pfizer; April 2019.
2. Humatrope® subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; October 2019.
3. Norditropin® subcutaneous injection [prescribing information]. Plainsboro, NJ: Novo Nordisk; March 2020.
4. Nutropin AQ® subcutaneous injection [prescribing information]. South San Francisco, CA: Genentech; December 2016.

5. Saizen[®], Saizenprep[®] subcutaneous injection [prescribing information]. Rockland, MA: EMD Serono; February 2020.
6. Zomacton[®] subcutaneous injection [prescribing information]. Parsippany, NJ: Ferring; July 2018.
7. Omnitrope[®] injection [prescribing information]. Princeton, NJ: Sandoz; June 2019.
8. Zorbtive[®] subcutaneous injection [prescribing information]. Rockland, MA: EMD Serono; September 2019.
9. Serostim[®] subcutaneous injection [prescribing information]. Rockland, MA: EMD Serono; June 2019.
10. Hart RJ, Rombauts L, Norman RJ. Growth hormone in IVF cycles: any hope? *Curr Opin Obstet Gynecol*. 2017;29(3):119-125.
11. Isfan F, Kanold J, Merlin E, et al. Growth hormone treatment impact on growth rate and final height of patients who received HSCT with TBI or/and cranial irradiation in childhood: a report from the French Leukaemia Long-Term Follow-Up Study (LEA). *Bone Marrow Transplant*. 2012;47:684-693
12. Cohen P, Rogol AD, Deal CL, et al; 2007 ISS Consensus Workshop participants. Consensus statement on the diagnosis and treatment of children with idiopathic short stature: a summary of the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop. *J Clin Endocrinol Metab*. 2008;93:4210-4217.
13. Wilson TA, Rose SR, Cohen P, et al. Update of guidelines for the use of growth hormone in children: the Lawson Wilkins Pediatric Endocrinology Society Drug and Therapeutics Committee. *J Pediatr*. 2003;143:415-421.
14. Freemark M. Editorial: Growth hormone treatment of "idiopathic short stature": not so fast. *J Clin Endocrinol Metab*. 2004;89:3138-3139.
15. Molitch ME, Clemmons DR, Malozowski S, et al; Endocrine Society. Evaluation and treatment of adult growth hormone deficiency: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2011;96:1587-1609.
16. Ho KK; 2007 GH Deficiency Consensus Workshop Participants. Consensus guidelines for the diagnosis and treatment of adults with GH deficiency II: a statement of the GH Research Society in association with the European Society for Pediatric Endocrinology, Lawson Wilkins Society, European Society of Endocrinology, Japan Endocrine Society, and Endocrine Society of Australia. *Eur J Endocrinol*. 2007;157:695-700.
17. Melmed S. Idiopathic adult growth hormone deficiency. *J Clin Endocrinol Metab*. 2013;98:2187-2197.
18. Clemmons DR, Molitch M, Hoffman AR, et al. Growth hormone should be used only for approved indications. *J Clin Endocrinol Metab*. 2014;99:409-411.
19. Fine RN, Martz K, Stablein D. What have 20 years of data from the North American Pediatric Renal Transplant Cooperative Study taught us about growth following renal transplantation in infants, children, and adolescents with end-stage renal disease? *Pediatr Nephrol*. 2010;25:739-746.
20. Drube J, Wan M, Bonthuis M, et al; European Society for Paediatric Nephrology Chronic Kidney Disease Mineral and Bone Disorders, Dialysis, and Transplantation Working Groups. Clinical practice recommendations for growth hormone treatment in children with chronic kidney disease. *Nat Rev Nephrol*. 2019;15(9):577-589.
21. Noonan JA, Kappelgaard AM. The efficacy and safety of growth hormone therapy in children with Noonan syndrome: a review of the evidence. *Horm Res Paediatr*. 2015;83:157-166.
22. Deal CL, Tony M, Höybye C, et al; 2011 Growth Hormone in Prader-Willi Syndrome Clinical Care Guidelines Workshop Participants. Growth Hormone Research Society workshop summary: consensus guidelines for recombinant human growth hormone therapy in Prader-Willi syndrome. *J Clin Endocrinol Metab*. 2013;98:E1072-E1087.
23. Blum WF, Crowe BJ, Quigley CA, et al; for the Shox Study Group. Growth hormone is effective in treatment of short stature associated with short stature homeobox-containing gene: two-year results of a randomized, controlled, multi-center trial. *J Clin Endocrinol Metab*. 2007;92:219-228.
24. Blum WF, Ross JL, Zimmermann AG, et al. GH treatment to final height produces similar height gains in patients with SHOX deficiency and Turner syndrome: results of a multicenter trial. *J Clin Endocrinol Metab*. 2013 Aug;98(8):E1383-1392.
25. Gravholt CH, Andersen NH, Conway GS, et al; International Turner Syndrome Consensus Group. Clinical practice guidelines for the care of girls and women with Turner syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting. *Eur J Endocrinol*. 2017;177(3):G1-G70.

26. Badowski M, Pandit NS. Pharmacologic management of human immunodeficiency virus wasting syndrome. *Pharmacotherapy*. 2014;34:868-881.
27. Yuen KC, Tritos NA, Samson SL, et al. American Association of Clinical Endocrinologists, American College of Endocrinology disease state clinical review: update on growth hormone stimulation testing and proposed revised cut-point for the glucagon stimulation test in the diagnosis of adult growth hormone deficiency. *Endocr Pract*. 2016;22(10):1235-1244.
28. Guzman J, Kerr T, Ward LM, et al. Growth and weight gain in children with juvenile idiopathic arthritis: results from the ReACCh-Out cohort. *Pediatr Rheumatol Online J*. 2017;15(1):68.
29. Macrilen™ oral solution [prescribing information]. Plainsboro, NJ: Novo Nordisk; July 2021.
30. Andersen M. The robustness of diagnostic tests for GH deficiency in adults. *Growth Horm IGF Res*. 2015;25:108-114.
31. Grimberg A, DiVall SA, Polychronakos C, et al; Drug and Therapeutics Committee and Ethics Committee of the Pediatric Endocrine Society. Guidelines for growth hormone and insulin-like growth factor-I treatment in children and adolescents: growth hormone deficiency, idiopathic short stature, and primary insulin-like growth factor-I deficiency. *Horm Res Paediatr*. 2016;86(6):361-397.
32. Vance ML. Can growth hormone prevent aging? *N Engl J Med*. 2003;348:779-780.
33. Liu H, Bravata DM, Olkin I, et al. Systematic review: the safety and efficacy of growth hormone in the healthy elderly. *Ann Intern Med*. 2007;146:104-115.
34. Pope HG Jr, Wood RI, Rogol A, et al. Adverse health consequences of performance-enhancing drugs: an Endocrine Society scientific statement. *Endocr Rev*. 2014;35:341-375.
35. Carel JC, Eugster EA, Rogol A, et al on behalf of the members of the ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123:e752-762.
36. Carel JC, Leger J. Precocious puberty. *N Engl J Med*. 2008;358:2366-2377.
37. Cleare AJ, Sookdeo SS, Jones J, et al. Integrity of the growth hormone/insulin-like growth factor system is maintained in patients with chronic fatigue syndrome. *J Clin Endocrinol Metab*. 2000;85:1433-1439.
38. Lin-Su K, Harbison MD, Lekarev O, et al. Final adult height in children with congenital adrenal hyperplasia treated with growth hormone. *J Clin Endocrinol Metab*. 2011;96:1710-1717.
39. Speiser PW, Arlt W, Auchus RJ, et al. Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2018;103(11):4043-4088.
40. De Luca F, Argente J, Cavallo L, et al; International Workshop on Management of Puberty for Optimum Auxological Results. Management of puberty in constitutional delay of growth and puberty. *Pediatr Endocrinol Metab*. 2001;14 Suppl 2:953-957.
41. Simon D, Prieur AM, Quartier P, et al. Early recombinant human growth hormone treatment in glucocorticoid-treated children with juvenile idiopathic arthritis: a 3-year randomized study. *J Clin Endocrinol Metab*. 2007;92:2567-2573.
42. Bechtold S, Ripperger P, Dalla Pozza R, et al. Growth hormone increases final height in patients with juvenile idiopathic arthritis: data from a randomized controlled study. *J Clin Endocrinol Metab*. 2007;92:3013-3018.
43. Puustinen L, Jalanko H, Holmberg C, et al. Recombinant human growth hormone treatment after liver transplantation in childhood: the 5-year outcome. *Transplantation*. 2005;79:1241-1246.
44. Wakeling EL, Brioude F, Lokulo-Sodipe O, et al. Diagnosis and management of Silver-Russell syndrome: first international consensus statement. *Nat Rev Endocrinol*. 2017;13(2):105-124.
45. Cuatrecasas G, Alegre C, Fernandez-Solà J, et al. Growth hormone treatment for sustained pain reduction and improvement in quality of life in severe fibromyalgia. *Pain*. 2012;153:1382-1389.
46. Geenen R, Jacobs JW, Bijlsma JW. Evaluation and management of endocrine dysfunction in fibromyalgia. *Rheum Dis Clin North Am*. 2002;28:389-404.
47. Homburg R, Singh A, Bhide P, et al. The re-growth of growth hormone in fertility treatment: a critical review. *Hum Fertil (Camb)*. 2012;15:190-193.
48. Shadid S, Jensen MD. Effects of growth hormone administration in human obesity. *Obes Res*. 2003;11:170-175.
49. Mekala KC, Tritos NA. Effects of recombinant human growth hormone therapy in obesity in adults: a meta-analysis. *J Clin Endocrinol Metab*. 2009;94:130-137.
50. Krantz E, Trimpou P, Landin-Wilhelmsen K. Effect of growth hormone treatment on fractures and quality of life in postmenopausal osteoporosis: A 10-Year follow-up study. *J Clin Endocrinol Metab*. 2015;100:3251-3259.

51. Gillberg P, Mallmin H, Petren-Mallmin M, et al. Two years of treatment with recombinant human growth hormone increases bone mineral density in men with idiopathic osteoporosis. *J Clin Endocrinol Metab.* 2002;87:4900-4906.
52. Quigley CA, Zagar AJ, Liu CC, et al. United States multicenter study of factors predicting the persistence of GH deficiency during the transition period between childhood and adulthood. *Int J Pediatr Endocrinol.* 2013;2013(1):6.
53. Yuen K, Biller B, Radovick S, et al. American Association of Clinical Endocrinologists and American College of Endocrinology guidelines for management of growth hormone deficiency in adults and patients transitioning from pediatric to adult care. *Endocr Pract.* 2019;25(11):1191-1232.
54. Butler MG, Miller JL, Forster SL. Prader-Willi syndrome – clinical genetics, diagnosis, and treatment approaches: an update. *Curr Pediatr Rev.* 2019;15(4):207-244.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	<p>Policy Statement: Updated the policy statement to note that approval requires somatropin to be evaluated by a physician who specializes in the condition being treated. Previously was approval required somatropin to be prescribed by or in consultation with a physician who specializes in the condition being treated.</p> <p>Growth Hormone Deficiency in a Child or Adolescent: In the requirement for at least one risk factor for growth hormone deficiency, examples were moved from the criteria into a note. In the criteria for congenital hypopituitarism, the requirement for at least one other pituitary hormone deficiency and/or has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk was updated to change “and/or” to “or”. In continuation criteria, the age ranges were clarified such that “≥ 12 to ≤ 18 years of age” was changed to “≥ 12 to < 18 years of age” and “adolescents or young adults > 18 years of age” was changed to “≥ 18 years of age”.</p> <p>Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent: In continuation criteria, the age ranges were clarified such that “≥ 12 to ≤ 18 years of age” was changed to “≥ 12 to < 18 years of age” and “adolescents or young adults > 18 years of age” was changed to “≥ 18 years of age”.</p> <p>Child Born Small for Gestational Age or with Intrauterine Growth Restriction (Retardation) Including a Child with Silver-Russell Syndrome: In continuation criteria, the age ranges were clarified such that “≥ 12 to ≤ 18 years of age” was changed to “≥ 12 to < 18 years of age” and “adolescents or young adults > 18 years of age” was changed to “≥ 18 years of age”.</p>	03/09/2022
Selected Revision	<p>Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent: Criteria related to patient’s baseline height was updated to ≤ 1.2 percentile or a standard deviation score (SDS) ≤ -2.25 for age and gender. Previously was less than 1.2 percentile or a SDS < -2.25 for age and gender.</p> <p>Child Born Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russell Syndrome: Removed the wording “retardation” after “intrauterine growth restriction”.</p>	03/16/2022

Annual Revision	<p>Growth Hormone Deficiency in a Child or Adolescent: Patient has panhypopituitarism was changed to patient has multiple pituitary hormone deficiencies. Also removed the following criterion: Patient has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary "bright spot" on magnetic resonance image or computed tomography."</p> <p>Growth Hormone Deficiency in an Adult or Transition Adolescent: Updated wording from "patient has known mutations, embryopathic lesions, congenital or genetic defects, or structural hypothalamic pituitary defects" to "patient has known perinatal insults OR congenital or genetic defects." Removed the word "alone" when referencing the arginine test.</p> <p>Chronic Kidney Disease in a Child or Adolescent: The following criterion was added for initial and continuation therapy: Patient has or had chronic kidney disease as defined by a glomerular filtration rate < 60 milliliters/minute. The following criterion was removed under initial therapy: "chronic kidney disease defined by abnormal creatinine clearance." The following criteria were added for initial criteria: Patient has persistent growth failure as defined by both of the following 1) Patient's baseline height is less than the 5th percentile for age and gender and 2) Patient's baseline height velocity is below the 25th percentile over a period of 3 months infants (\leq 1 year of age) or 6 months in children and adolescents.</p> <p>Noonan Syndrome in a Child or Adolescent: The following criteria was added for initial and continuation therapy: The diagnosis of Noonan syndrome has been confirmed by one of the following i) Noonan syndrome has been confirmed with genetic testing or ii) If genetic testing does not definitively confirm the diagnosis, the prescriber has made a clinical diagnosis of Noonan syndrome and note was added with a description of a clinical diagnosis.</p> <p>Prader-Willi Syndrome: The following criterion was added for initial and continuation therapy: The diagnosis of Prader-Willi syndrome has been confirmed by genetic testing.</p> <p>Short Stature Homeobox-Containing Gene Deficiency in a Child or Adolescent: The following criterion was added for continuation of therapy: Patient has short stature homeobox-containing gene deficiency demonstrated by chromosome analysis. For initial therapy, the patient's baseline height is less than the 3rd percentile for age and gender was changed to less than the 5th percentile.</p> <p>Child Born Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russell Syndrome: The following criteria was added for continuation of therapy: i) Patient was born small for gestational age, which is defined as birth weight and/or birth length that is > 2 standard deviations (SD) below the mean (< -2 SD) for gestational age and gender and ii) Patient did not have sufficient catch-up growth before age 2 to 4 years. Removed continuation of therapy criteria for patients \geq 18 years of age.</p> <p>Turner Syndrome: The following criterion was added for initial and continuation of therapy: The diagnosis of Turner's syndrome has been confirmed by karyotype analysis (i.e., chromosome analysis). The following criterion was added for</p>	04/05/2023
-----------------	--	------------

	<p>initial therapy: Patient's baseline height is less than the 5th percentile for age and gender; previous wording which stated that patient has short stature associated with Turner's syndrome was removed.</p> <p>Short Bowel Syndrome in an Adult: The following criterion was added to initial therapy: Patient is dependent on intravenous parenteral nutrition.</p> <p>Human Immunodeficiency Virus Infection with Wasting or Cachexia in an Adult: The following criteria was added: i) Patient has tried one appetite stimulant or other anabolic agent or ii) Appetite stimulants or other anabolic agents are contraindicated.</p>	
Selected Revision	<p>Changes effective for 1.1.2024:</p> <p>Growth Hormone Deficiency in a Child or Adolescent: Criterion that specified the result of a growth hormone stimulation test to be < 10 ng/mL was added. Criterion that the stimulation test show an inadequate response as defined by a peak response below the normal reference range as determined by the testing laboratory was removed.</p>	11/01/2023

"Cigna Companies" refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2023 Cigna