UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Egrifta

Program	Prior Authorization/Notification
Medication	Egrifta SV™ (tesamorelin for injection)
Markets in Scope	Arizona, California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York CHIP, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	6/2011
Pharmacy and Therapeutics Approval Date	2/2021
Effective Date	4/2021

1. Background:

Egrifta SV (tesamorelin) is a growth hormone releasing factor (GHRF) analog indicated for the reduction of excess abdominal fat in HIV-infected patients with lipodystrophy. Since the long-term cardiovascular safety and potential long-term cardiovascular benefit of Egrifta treatment have not been studied and are not known, careful consideration should be given whether to continue Egrifta treatment in patients who do not show a clear efficacy response as judged by the degree of reduction in visceral adipose tissue measured by waist circumference or CT scan. Egrifta is not indicated for weight loss management (weight neutral effect). There is no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking Egrifta.

Coverage for Egrifta will be provided for patients who meet the following criteria:

2. Coverage Criteria:

A. <u>Authorization</u>

1. **Egrifta** will be approved based on the following criterion:

   a. Diagnosis of HIV-associated lipodystrophy

   Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Egrifta [package insert]. Montreal, Quebec, Canada. Theratechnologies, Inc. October 2019.

Program	Prior Authorization - Egrifta (tesamorelin for injection)
Change Control	
6/2011	New guideline
6/2012	Annual Review
6/2013	Converted policy to new UHC enterprise wide formatting. Added age requirement. No other changes to clinical criteria.
3/2015	Removed extraneous endnotes and renumbered endnotes. Added endnote to document reason for keeping age criteria. No change to criteria
10/2016	Updated policy template. Updated clinical criteria to align with Employer & Individual.
2/2017	Updated policy template
3/2017	Changed initial and reauthorization duration from 6 months to 12 months
9/2017	Removed reauthorization criteria to allow for Dx to Rx implementation
2/2018	Annual review. No change to clinical criteria.
2/2019	Annual review. Updated references.
2/2020	Annual review. No changes to clinical criteria.
2/2021	Annual review. No changes to clinical coverage. Updated background and references.