UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1027-13
Program	Prior Authorization/Notification
Medication	Egrifta SV™ (tesamorelin for injection)
P&T Approval Date	5/2011, 5/2012, 5/2013, 4/2014, 4/2015, 2/2016, 2/2017, 2/2018, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 2/2024, 2/2025
Effective Date	5/1/2025

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.

Limitations of Use:
- Long-term cardiovascular safety of Egrifta SV has not been established.
- Not indicated for weight loss management.
- There are 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]:

A. Initial Authorization

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

   a. Diagnosis of HIV-associated lipodystrophy

   Authorization will be issued for 12 months.

B. Reauthorization

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

   a. Documentation of positive clinical response (e.g., improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance) while on Egrifta therapy.

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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 [prescribing information]. Montreal, Quebec, Canada: Theratechnologies, Inc.; February 2024.

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Change Control	
4/2014	Annual review with age assessment resulting in no change in clinical coverage. Updated references.
4/2015	Annual review with no change in clinical coverage. Updated references.
2/2016	Annual review. Modified initial coverage criteria to require only a diagnosis. Updated references.
2/2017	Annual review. No change in clinical coverage.
2/2018	Annual review. No change in clinical coverage.
2/2019	Annual review. No change in clinical coverage.
2/2020	Annual review. Updated reauthorization duration to 12 months.
2/2021	Annual review. No changes to clinical coverage. Updated background and references.
2/2022	Annual review. No changes to clinical coverage.
2/2023	Annual review with no changes to coverage criteria. Updated background, references and added state mandate footnote.
2/2024	Annual review with no changes to coverage criteria.
2/2025	Annual review. Updated initial authorization to 12 months and updated reference.