Clinical Policy: Somatropin (Human Growth Hormone)
Reference Number: CP.PCH.25
Effective Date: 01.01.20
Last Review Date: 02.20
Line of Business: Commercial, HIM

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are recombinant human growth hormones (GH) requiring prior authorization: somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®).

FDA Approved Indication(s)
Genotropin is indicated for treatment of:
- Children with GF due to GHD, PWS, SGA, TS, and ISS.
- Adults with either childhood-onset (CO) or adult-onset (AO) GHD.

Humatrope is indicated for treatment of:
- Children with SS or GF associated with GHD, TS, ISS, SHOX deficiency, and failure to catch up in height after SGA birth.
- Adults with either CO or AO GHD.

Norditropin FlexPro is indicated for the treatment of:
- Children with GF due to GHD, SS associated with NS, SS associated with TS, SS born SGA with no catch-up growth by age 2 to 4 years, ISS, and GF due to PWS.
- Adults with either CO or AO GHD.

Nutropin AQ is indicated for the treatment of:
- Children with GF due to GHD, ISS, TS, and CKD up to the time of renal transplantation.
- Adults with either CO or AO GHD.
Omnitrope is indicated for the treatment of:
- Children with GF due to GHD, PWS, SGA, TS, and ISS.
- Adults with either CO or AO GHD.

Saizen is indicated for:
- Children with GF due to GHD.
- Adults with either CO or AO 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:
- Treatment of pediatric patients who have GF due to inadequate secretion of normal endogenous GH, SS associated with TS, ISS, SS or GF in SHOX deficiency, and SS born SGA with no catch-up growth by 2 years to 4 years.
- Replacement of endogenous GH in adults with GHD.

Zorbtive is indicate for treatment of:
- SBS in adult patients receiving specialized nutritional support.

**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.

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   E. Other diagnoses/indications

III. Diagnoses/Indications for which coverage is NOT authorized:
IV. Appendices
It is the policy of health plans affiliated with Centene Corporation® that somatropin (recombinant human growth hormone (rhGH)) **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. Prescribed by or in consultation with a pediatric endocrinologist;
   3. Age ≤ 1 month;
   4. Serum GH concentration ≤ 5 µg/L;
   5. Member meets (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);
   6. The requested product is not prescribed concurrently with Increlex® (mecasermin);
   7. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
   8. Dose does not exceed 0.30 mg/kg per week.
   
   **Approval duration: 6 months or to member’s renewal period whichever is longer**

B. Growth Hormone Deficiency with Short Stature/Growth Failure - Children (open epiphyses) (must meet all):
   1. Diagnosis of GHD;
   2. Prescribed by or in consultation with a pediatric endocrinologist;
   3. Age < 18 years;
   4. If age > 10 years, open epiphysis on x-ray;
   5. Member meets (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;
   6. Member meets (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. 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);
   7. Member meets (a or b):
      a. SS: height < -2 SD below the mean for age and gender (SD and height within the last 90 days required);
b. GF: growth has slowed by more than 1 SD in ≥ 6 months (SD and 2 heights ≥ 6 months apart within the last year required);
8. The requested product is not prescribed concurrently with Increlex (mecasermin);
9. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
10. Dose does not exceed 0.30 mg/kg per week.

**Approval duration: 6 months or to member’s renewal period whichever is longer**

**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. Prescribed by or in consultation with a pediatric endocrinologist;
3. Age < 18 years;
4. If age > 10 years, open epiphysis on x-ray;
5. Member meets (a or b):
   a. SS: height < -2 SD (< -1.5 SD if TS) below the mean for age and gender (SD and height within the last 90 days required);
   b. GF: growth has slowed by more than 1 SD in ≥ 6 months (SD and 2 heights ≥ 6 months apart within the last year required);
6. The requested product is not prescribed concurrently with Increlex (mecasermin);
7. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
8. Request meets one of the following (a, b, or c):
   a. PWS: Dose does not exceed 0.24 mg/kg per week;
   b. TS, NS: Dose does not exceed 0.5 mg/kg per week;
   c. SHOX deficiency: Dose does not exceed 0.35 mg/kg per week.

**Approval duration: 6 months or to member’s renewal period whichever is longer**

**D. Chronic Kidney Disease with Growth Failure – Children** (must meet all):
1. Diagnosis of CKD;
2. Prescribed by or in consultation with a pediatric endocrinologist or nephrologist;
3. Age < 18 years;
4. If age > 10 years, open epiphysis on x-ray;
5. Member meets (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;
6. Member meets (a or b):
   a. SS: height < -2 SD below the mean for age and gender (SD and height within the last 90 days required);
   b. GF: growth has slowed by more than 1 SD in ≥ 6 months (SD and 2 heights ≥ 6 months apart within the last year required);
7. The requested product is not prescribed concurrently with Increlex (mecasermin);
8. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
9. Dose does not exceed 0.35 mg/kg per week.

**Approval duration: 6 months or to member’s renewal period whichever is longer**

**E. Born Small for Gestational Age with Short Stature/Growth Failure - Children** (must meet all):

1. Diagnosis of SGA:
2. Prescribed by or in consultation with a pediatric endocrinologist;
3. Age ≥ 2 years and < 18 years;
4. If age > 10 years, open epiphysis on x-ray;
5. Member meets (a and b):
   a. Birth weight or length < -2 SD below the mean for gestational age (birth weight and length, with SD, required);
   b. Current height < -2 SD below the mean for age and gender (measured within the last year at ≥ 2 years of age, SD, and height required);
6. The requested product is not prescribed concurrently with Increlex (mecasermin);
7. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
8. Dose does not exceed 0.48 mg/kg per week.

**Approval duration: 6 months or to member’s renewal period whichever is longer**

**F. Idiopathic Short Stature - Children** (must meet all):

1. Diagnosis of ISS;
2. Prescribed by or in consultation with a pediatric endocrinologist;
3. Age < 18 years;
4. If age > 10 years, confirmation of open epiphysis on x-ray;
5. Member meets one of the following (a and b):
   a. Height < -2.25 SD below the mean for age and gender (SD and height within the last 90 days required);
   b. Not likely to attain adult height in the normal range (< 63 inches for males and < 59 inches for females);
6. The following conditions have been ruled out (a, b, and c):
   a. Short stature related to GHD, genetic disease, CKD, SGA;
   b. 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);
   c. Constitutional delay of growth and puberty (i.e., the member’s growth rate is delayed compared to chronological age but appropriate for bone age as determined by x-ray);
7. Not prescribed concurrently with Increlex (mecasermin);
8. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
9. Dose does not exceed 0.30 mg/kg per week.
Approval duration: 6 months or to member’s renewal period whichever is longer

G. 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 (a, b, or c):
   a. 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);
   b. 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;
   c. One low IGF-I serum level and (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 NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
8. Dose does not exceed 0.4 mg/day (may adjust by up to 0.2 mg/day every 6 weeks to maintain normal IGF-1 serum levels; doses > 1.6 mg/day would be uncommon).

Approval duration: 6 months or to member’s renewal period whichever is longer

H. Short Bowel Syndrome (must meet all):
1. Diagnosis of SBS;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Patient is dependent upon and receiving intravenous nutrition;
5. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
6. Dose does not exceed 8 mg per day.

Approval duration: up to 4 weeks total

I. HIV-Associated Wasting or Cachexia (must meet all):
1. Diagnosis of HIV;
2. Prescribed by or in consultation with a physician specializing in HIV management;
3. Age ≥ 18 years;
4. Unintentional weight loss of ≥ 10% in the last 12 months occurring while on antiretroviral therapy;
5. Failure of at least 2 pharmacologic therapies from two separate drug classes (Appendix B) unless contraindicated or clinically adverse effects are experienced;
6. If request is NOT for Norditropin or Humatrope: Norditropin and Humatrope product excipients are contraindicated or member has experienced clinically significant adverse effects to Norditropin and Humatrope;
7. Dose does not exceed 6 mg per day.

Approval duration: 6 months or to member’s renewal period whichever is longer (up to 12 months total)

J. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

II. Continued Therapy
A. All Pediatric Indications (open epiphyses) (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Age < 18 years OR open epiphysis on x-ray;
   3. Member meets (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 with or without neonatal hypoglycemia, ISS: 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: 6 months or to member’s renewal period whichever is longer

B. Growth Hormone Deficiency - Adults and Transition Patients (closed epiphyses) (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. For IGF-1 test results and dosing (test conducted within the last 90 days) (a, b, or c):
a. Low IGF-1 serum level: 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: 6 months or to member’s renewal period whichever is longer

C. Short Bowel Syndrome - Adults (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
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 8 mg per day.

Approval duration: up to 4 weeks total

D. HIV-Associated Wasting/Cachexia - Adults (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
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: 6 months or to member’s renewal period whichever is longer (up to 12 months total)

E. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via health plan benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

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 policy – CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace, or evidence of coverage documents.
B. 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);
C. 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);
D. Adult short stature or altered body habitus associated with antiviral therapy (other than HIV-associated wasting or cachexia);
E. Obesity treatment or enhancement of body mass/strength for non-medical reasons (e.g., athletic gains).

IV. Appendices/General Information

Appendix A: Abbreviation

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD</td>
<td>chronic kidney disease</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>GFR</td>
<td>glomerular filtration rate</td>
</tr>
<tr>
<td>GH</td>
<td>growth hormone</td>
</tr>
<tr>
<td>GHD</td>
<td>growth hormone deficiency</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>IGF-1</td>
<td>insulin-like growth factor-1</td>
</tr>
<tr>
<td>IGFBP-3</td>
<td>insulin-like growth factor binding protein-3</td>
</tr>
<tr>
<td>ISS</td>
<td>idiopathic short stature</td>
</tr>
<tr>
<td>NS</td>
<td>Noonan syndrome</td>
</tr>
<tr>
<td>PWS</td>
<td>Prader-Willi syndrome</td>
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<tr>
<td>rhGH</td>
<td>recombinant human growth hormone</td>
</tr>
<tr>
<td>SBS</td>
<td>short bowel syndrome</td>
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<tr>
<td>SD</td>
<td>standard deviation</td>
</tr>
<tr>
<td>SGA</td>
<td>small for gestational age</td>
</tr>
<tr>
<td>SHOX</td>
<td>short stature homeobox-containing gene</td>
</tr>
<tr>
<td>TS</td>
<td>Turner syndrome</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appetite Stimulants</strong></td>
<td></td>
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</tr>
<tr>
<td>Megestrol (Megace®)</td>
<td>400 - 800 mg PO daily (10 – 20 ml/day)</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Dronabinol (Marinol®)</td>
<td>2.5 mg PO bid</td>
<td>20 mg/day</td>
</tr>
<tr>
<td><strong>Testosterone Replacement Products</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testosterone enanthate or cypionate (Various brands)</td>
<td>50 - 400 mg IM Q2 – 4 wks</td>
<td>400 mg Q 2 wks</td>
</tr>
<tr>
<td>Androderm® (testosterone transdermal)</td>
<td>2.5 – 7.5 mg patch applied topically QD</td>
<td>7.5 mg/day</td>
</tr>
<tr>
<td>Androgel® (testosterone gel)</td>
<td>5 - 10 gm gel (delivers 50 – 100 mg testosterone) applied topically QD</td>
<td>10 gm/day gel (100 mg/day testosterone)</td>
</tr>
<tr>
<td>Testim® (testosterone gel)</td>
<td>5 - 10 gm gel (delivers 50 – 100 mg testosterone) applied topically QD</td>
<td>10 gm/day gel (100 mg/day testosterone)</td>
</tr>
<tr>
<td><strong>Anabolic Steroids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxandrolone (Oxandrin®)</td>
<td>2.5 – 20 mg PO /day</td>
<td>20 mg/day</td>
</tr>
<tr>
<td>Nandrolone decanoate</td>
<td>100 mg IM Q week</td>
<td>100 mg Q wk</td>
</tr>
<tr>
<td><strong>Nausea/Vomiting Treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chlorpromazine</td>
<td>10 to 25 mg PO q4 to 6 hours prn</td>
<td>2,000 mg/day</td>
</tr>
<tr>
<td>perphenazine</td>
<td>8 to 16 mg/day PO in divided doses</td>
<td>64 mg/day</td>
</tr>
</tbody>
</table>
### Therapeutic Alternatives

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 differ based on specific formulary used.

### Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s):**
  - 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

- **Boxed warning(s):** none reported

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Zomacton</td>
<td>GHD</td>
<td>0.16 to 0.24 mg/kg/week</td>
<td>See dosing regimens</td>
</tr>
<tr>
<td>Genotropin, Norditropin, Omnitrope</td>
<td>PWS</td>
<td>0.24 mg/kg/week</td>
<td>0.24 mg/kg/week</td>
</tr>
<tr>
<td>Genotropin, Humatrope, Norditropin, Omnitrope, Zomacton</td>
<td>SGA</td>
<td>to 0.48 mg/kg/week</td>
<td>0.48 mg/kg/week</td>
</tr>
<tr>
<td>Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Zomacton</td>
<td>TS</td>
<td>0.33 mg/kg/week to 0.375 mg/kg/week</td>
<td>See dosing regimens</td>
</tr>
<tr>
<td>Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Zomacton</td>
<td>ISS</td>
<td>0.47 mg/kg/week to 0.37 mg/kg/week</td>
<td>See dosing regimens</td>
</tr>
<tr>
<td>Humatrope, Zomacton</td>
<td>SHOX</td>
<td>0.35 mg/kg/week</td>
<td>0.35 mg/kg/week</td>
</tr>
<tr>
<td>Norditropin</td>
<td>NS</td>
<td>0.46 mg/kg/week</td>
<td>0.46 mg/kg/week</td>
</tr>
<tr>
<td>Nutropin</td>
<td>CKD</td>
<td>0.35 mg/kg/week</td>
<td>0.35 mg/kg/week</td>
</tr>
</tbody>
</table>
### Adult Indications (Subcutaneous administration)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Zomacton</td>
<td>GHD</td>
<td>0.4 mg/day - may adjust by increments up to 0.2 mg/day every 6 weeks to maintain normal IGF-1 serum levels.*</td>
<td>See dosing regimen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Dosing regimen from Endocrine Society guidelines (Fleseriu, et al., 2016).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult GHD dosing should be substantially lower than that prescribed for children. Adult doses beyond 1.6 mg/day would be uncommon.</td>
<td></td>
</tr>
<tr>
<td>Serostim</td>
<td>HIV-associated wasting</td>
<td>0.1 mg/kg QOD or QD to 6 mg QD</td>
<td>6 mg/day up to 24 weeks</td>
</tr>
<tr>
<td>Zorbtive</td>
<td>SBS</td>
<td>0.1 mg/kg QD to 8 mg QD</td>
<td>8 mg/day up to 4 weeks</td>
</tr>
</tbody>
</table>

### VI. Product Availability

<table>
<thead>
<tr>
<th>Drug</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotropin lyophilized powder</td>
<td>Dual-chamber syringe: 5 mg, 12 mg</td>
</tr>
<tr>
<td>Genotropin Miniquick <strong>without preservative</strong></td>
<td>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</td>
</tr>
</tbody>
</table>
| Humatrope | Pen cartridge: 6 mg, 12 mg, 24 mg  
Vial: 5 mg |
| Norditropin Flexpro | Pen: 5 mg/1.5 mL, 10 mg/1.5 mL, 15 mg/1.5 mL, 30 mg/3 mL |
| Nutropin AQ | NuSpin: 5 mg/2 mL, 10 mg/2 mL, 20 mg/2 mL |
| Omnitrope | Pen cartridge: 5 mg/1.5 mL, 10 mg/1.5 mL  
Vial: 5.8 mg |
| Saizen | Pen cartridge: 8.8 mg  
Vial: 5 mg, 8.8 mg |
| Serostim | Vial: 4 mg, 5 mg, 6 mg |
| Zomacton | Vial: 5 mg, 10 mg |
| Zorbtive | Vial: 8.8 mg |

### VII. References

**FDA Labels**


Compandia

Somatropin Therapy - Children

GHD - Adults and Transition Patients

Short Bowel Syndrome

HIV-Associated Wasting

Somatropin Product Comparative Data


<table>
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<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<td>Policy created and adapted from CPA.CPA.84 and HIM.PA.SP39; CP.CPA.84 and HIM.PA.SP39 policies retired.</td>
<td>01.23.20</td>
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</table>

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.

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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.

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