

## PHARMACY PRE-AUTHORIZATION CRITERIA



<b>DRUG (S)</b>	Egrifta (tesamorelin)
<b>POLICY #</b>	22118
<b>INDICATIONS</b>	Egrifta is indicated for the reduction of excess abdominal fat in HIV-infected patients with lipodystrophy.
<b>CRITERIA</b>	<p>ConnectiCare considers Egrifta to be medically necessary for patients who meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Patient has clinically diagnosed human immunodeficiency virus (HIV infection)</li> <li>• Patient has excess accumulation of abdominal fat due to HIV-associated lipodystrophy with the following gender-specific measures:             <ol style="list-style-type: none"> <li>1. <u>For males:</u> <ol style="list-style-type: none"> <li>a. Waist circumference greater than 37.4 inches (95 cm)</li> <li><b>AND</b></li> <li>b. Waist-to-hip ratio greater than 0.94.</li> </ol> </li> <li><b>OR</b></li> <li>2. <u>For females:</u> <ol style="list-style-type: none"> <li>a. Waist circumference greater than 37 inches (94 cm)</li> <li><b>AND</b></li> <li>b. Waist-to-hip ratio greater than 0.88.</li> </ol> </li> </ol> </li> <li>• Patient must be or have been on a protease inhibitor and/or nucleoside reverse transcriptase inhibitor</li> </ul>
<b>LIMITATIONS</b>	If the above criteria are met initial authorization will be granted for 6 months. Subsequent authorization will be granted with clinical documentation indicating a decrease in waist circumference.
<b>REFERENCES</b>	Egrifta full prescribing information. Rockland,MA: EMDSerono, Inc.
<b>P&amp;T REVIEW HISTORY</b>	4/11, 12/11, 10/12, 10/13, 10/14, 11/15, 5/16, 5/17, 5/18, 5/19
<b>REVISION RECORD</b>	11/12

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