CLINICAL CRITERIA FOR UM DECISIONS

Egrifta® (tesamorelin)
Growth Hormone Releasing Factor (GRF) Analog

Capital Health Plan members between the ages of 18 and 65 years meeting the criteria below may be approved for coverage of Egrifta® based on their pharmacy benefit:

- The medication is prescribed for the reduction of excess abdominal fat in human immunodeficiency virus (HIV)-infected patients with lipodystropy, AND
- Patient does not have a history of hypophysectomy, hypopituitarism, pituitary tumor or surgery, head irradiation or head trauma, AND
- Patient is not pregnant, AND
- Patient is not allergic to mannitol, AND
- Any preexisting malignancy is inactive and its treatment complete prior to starting Egrifta® therapy, AND
- The prescriber is affiliated with CHP.

J Code	Product
J3590	Unclassified biologics

Route of administration: Subcutaneous

Medical Necessity Approvals to be made by:
- ☑ Medical Director
- ☑ Physician Reviewer
- ☐ Chief of Eye Care
- ☑ Medical Services Coordinator
- ☑ Utilization Management Nurse
- ☑ Authorized Pharmacy Services staff when UM criteria are met

These criteria apply to the following products when determined to be included in the member's benefit package:
- ☑ Commercial
- ☐ Medicare

Source Documents:
1. DailyMed website. Available at: http://dailymed.nlm.nih.gov. Accessed on 01/13/11.
2. Facts and Comparisons website. Available at: http://online.factsandcomparisons.com. Accessed on December 30, 2011.
3. Theratechnologies Inc. Egrifta® package insert. Rockland, MA: 2010 November.
4. Micromedex website. Available at: http://www.thomsonhc.com. Accessed on 12/30/2011.

Pharmacy Committee Approved: 2/10/11
Pharmacy Committee Reviewed and Approved: 1/17/12

Capital Health Plan reserves the right to make changes to these criteria at any time to accommodate changes in medical necessity and industry standards.