CareSource Rxinnovations

# PHARMACY POLICY STATEMENT
## Georgia Medicaid

| DRUG NAME | Egrifta SV, Egrifta WR (tesamorelin) |
|---|---|
| BENEFIT TYPE | Pharmacy |
| STATUS | Prior Authorization Required |

Egrifta SV and Egrifta WR are analogs of human growth hormone (GH)-releasing factor, indicated to reduce excess abdominal fat in HIV-infected patients with lipodystrophy. The main difference between SR and WR is that WR requires weekly reconstitution whereas SV requires daily reconstitution. Lipodystrophy can exist as lipoatrophy (loss of subcutaneous fat), lipohypertrophy (fat accumulated as excess visceral adipose tissue), or a mix of both. In contrast, obesity is an increase in subcutaneous fat. Egrifta SV and Egrifta WR have a weight neutral effect and should not be prescribed for obesity. They have a selective effect to reduce visceral fat but does not reduce subcutaneous fat.

Egrifta SV, Egrifta WR (tesamorelin) will be considered for coverage when the following criteria are met:

### HIV-associated Lipodystrophy

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an infectious disease specialist or endocrinologist; AND
3. Member has a diagnosis of HIV-associated lipodystrophy with excess abdominal fat (visceral adipose tissue); AND
4. If male, member has documentation of waist circumference > 95 cm **AND** waist to hip ratio > 0.94; OR
5. If female, member has documentation of waist circumference > 94 cm **AND** waist to hip ratio > 0.88; AND
6. Member has been stable on antiretroviral treatment for at least 8 weeks; AND
7. Provider attests medication is **NOT** being prescribed for simple obesity or weight loss; AND
8. Provider attests member does **NOT** have active malignancy.
9. **Dosage allowed/Quantity limit**:
   a) Egrifta SV: inject 1.4 mg subcutaneously once daily. Quantity limit: 30 vials per 30 days.
   b) Egrifta WR: inject 1.28 mg subcutaneously once daily. Quantity limit: 4 vials per 28 days.

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes must show there has been a reduction of excess visceral adipose tissue from baseline measured by **ONE** of the following:
   a) Computed tomography (CT) scan;
   b) Waist circumference;
   c) Waist to hip ratio.

***If all the above requirements are met, the medication will be approved for 12 months.***

**CareSource considers Egrifta SV, Egrifta WR (tesamorelin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.**

| DATE | ACTION/DESCRIPTION |
|---|---|
| **12/08/2020** | New policy for Egrifta SV created. |
| **09/20/2023** | Added quantity limit; added reference; removed attempt to switch from causative anti-retroviral drugs; added CT and waist to hip ratio as options to show reduction in reauthorization criteria; added waist circumference and waist to hip ratio criteria to confirm diagnosis; added that member is to be stable on ART for at least 8 weeks. |
| **06/07/2025** | Updated references; added Egrifta WR to policy including dosing.; added provider attestation to absence of active malignancy and that medication is not being prescribed for weight loss; added "HIV-associated" to the table title of "lipodystrophy"; updated policy summary |

References:


1. Egrifta SV [package insert]. Montreal, Quebec, Canada: Theratechnologies Inc; 2024.
2. Egrifta WR [prescribing information]. Theratechnologies Inc; 2025.
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6. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/AdultandAdolescentGL.pdf. Accessed 12/30/2020.
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