Humana. CareSource™

PHARMACY POLICY STATEMENT
Kentucky Medicaid

DRUG NAME	Macrilen (macimorelin)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— for weight ≤ 120 kg - 1 pouch >120 kg - 2 pouches
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Macrilen (macimorelin) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DIAGNOSTIC USE FOR GROWTH HORMONE DEFICIENCY

For **initial** authorization:

1. Member is age 18 years or older; AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member's weight is documented on chart notes and member's BMI is ≤ 40 kg/m^2; AND
4. Member must have a contraindication to ALL other diagnostic tests (insulin tolerance test, glucagon stimulation test, arginine, clonidine, levodopa, or arginine combined with levodopa) for growth hormone deficiency.
5. **Dosage allowed:** 0.5 mg/kg as single dose.

If member meets all the requirements listed above, the medication will be approved for a one-time fill and will not be reauthorized.

CareSource considers Macrilen (macimorelin) not medically necessary for the diagnosis or treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/20/2018	New policy for Macrilen created.

References:

1. Macrilen [prescribing information]. Trevose, PA: Strongbridge US Inc.; Revised January 2018.
2. Garcia JM et al., *J Clin Endocrinol Metab*. 2018 May 31.
3. Diagnosis of growth hormone deficiency in childhood. *Curr Opin Endocrinol Diabetes Obes*. 2012;19(1):47-52.

Effective date: 02/01/2019
Revised date: 10/20/2018