



STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

SOMATROPIN - OMNITROPE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
SOMATROPIN	OMNITROPE	02824		GPI-10 (3010002000)	BRAND = OMNITROPE

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is the request for treatment of **ANY** of the following?

- Athletic enhancement
- Anti-aging purposes
- Idiopathic short stature

If yes, do not approve.

DENIAL TEXT: See the initial denial text at the end of the guideline

If no, continue to #2.

2. Does the patient have **ONE** of the following diagnoses and meet the associated criteria?

For pediatric growth hormone deficiency (GHD), approval requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient had a trial of or contraindication to the preferred agent: Norditropin
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand)
- The patient meets at least ONE of the following criteria for short stature:
 - Patient's height is greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender
 - Height velocity less than the 25th percentile for age
 - Documented low peak growth hormone (less than 10ng/mL) on two GH stimulation tests or insulin-like growth factor 1 (IGF-1) greater than or equal to 2 SD below the mean for age and gender

For growth failure due to Prader-Willi syndrome (PWS), approval requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- Confirmed genetic diagnosis of PWS
- The patient had a trial of or contraindication to the preferred agent: Norditropin
(Initial criteria continued on next page)

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INITIAL CRITERIA (CONTINUED)

For growth failure in children born small for gestational age (SGA), approval requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- Patient with no catch-up growth by age 2 years
- The patient had a trial of or contraindication to the preferred agent: Norditropin
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand)
- The patient's height is greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender

For growth failure associated with Turner syndrome, approval requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient had a trial of or contraindication to the preferred agent: Norditropin
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand)
- The patient's height is greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender

For adult growth hormone deficiency, approval requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient had a trial of or contraindication to the preferred agent: Norditropin
- The patient has growth hormone deficiency alone or associated with multiple hormone deficiencies (hypopituitarism), as a result of pituitary diseases, hypothalamic disease, surgery, radiation therapy, trauma, or continuation of therapy from childhood onset growth hormone deficiency

If yes, **approve for 12 months by GPID or GPI-14 for all strengths.**

If no, do not approve.

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **SOMATROPIN (Omnitrope)** requires the following rule(s) be met for approval:

A. You have ONE of the following diagnoses:

1. Pediatric growth hormone deficiency (GHD: a type of hormone disorder with low growth hormone)
2. Growth failure due to Prader-Willi syndrome (PWS: a type of gene condition)
3. Growth failure in children born small for gestational age (SGA)
4. Growth failure associated with Turner syndrome (TS: a type of gene condition)
5. Adult growth hormone deficiency

(Initial denial text continued on next page)

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INITIAL CRITERIA (CONTINUED)

This medication will not be approved for treatment of ANY of the following conditions:

1. Athletic enhancement
2. Anti-aging purposes
3. Idiopathic short stature (unknown cause of short height)
- B. **If you have pediatric growth hormone deficiency, approval also requires:**
 1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. You had a trial of or contraindication (harmful for) to the preferred medication: Norditropin
 3. Your epiphyses (end part of long bone) are NOT closed as confirmed by radiograph (type of imaging test) of the wrist and hand
 4. You meet at least ONE of the following criteria for short stature:
 - a. Your height is greater than or equal to 2 standard deviations (SD) below the mean (average) height for normal children of the same age and gender
 - b. Your height velocity is less than the 25th percentile for your age
 - c. You have documented low peak growth hormone (less than 10ng/mL) on two growth hormone stimulation tests or insulin-like growth factor 1 (IGF-1) greater than or equal to 2 standard deviations below the mean for your age and gender
- C. **If you have growth failure due to Prader-Willi syndrome, approval also requires:**
 1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. You have confirmed genetic diagnosis of Prader-Willi Syndrome
 3. You had a trial of or contraindication (harmful for) to the preferred medication: Norditropin
- D. **If you have growth failure and are a child born small for gestational age, approval also requires:**
 1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. You had no catch-up growth by age 2 years
 3. You had a trial of or contraindication (harmful for) to the preferred medication: Norditropin
 4. Your epiphyses (end part of long bone) are NOT closed as confirmed by radiograph (type of imaging test) of the wrist and hand
 5. Your height is greater than or equal to 2 standard deviations (SD) below the mean (average) height for normal children of the same age and gender
- E. **If you have growth failure associated with Turner syndrome, approval also requires:**
 1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. You had a trial of or contraindication (harmful for) to the preferred medication: Norditropin
 3. Your epiphyses (end part of long bone) are NOT closed as confirmed by radiograph (type of imaging test) of the wrist and hand
 4. Your height is greater than or equal to 2 standard deviations (SD) below the mean (average) height for normal children of the same age and gender

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INITIAL CRITERIA (CONTINUED)

F. If you have adult growth hormone deficiency, approval also requires:

1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
2. You had a trial of or contraindication (harmful for) to the preferred medication: Norditropin
3. You have growth hormone deficiency alone or associated with multiple hormone deficiencies (hypopituitarism), as a result of pituitary diseases (disease of a major hormone producing gland), hypothalamic disease (disease of a small area of the brain important for hormone production and body processes), surgery, radiation therapy, trauma, or continuation of therapy from childhood onset growth hormone deficiency

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RENEWAL CRITERIA

1. Is the request for treatment of **ANY** of the following?

- Athletic enhancement
- Anti-aging purposes
- Idiopathic short stature

If yes, do not approve.

DENIAL TEXT: See the renewal denial text at the end of the guideline.

If no, continue to #2.

2. Does the patient have **ONE** of the following diagnoses and meet the associated criteria?

For pediatric growth hormone deficiency (GHD), renewal requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand or the patient has not completed prepubertal growth)
- The patient meets ONE of the following:
 - Annual growth velocity of 2 cm or more compared with what was observed from the previous year
 - Annual growth velocity of 1 cm or more compared with what was observed from the previous year in patients who are near the terminal phase of puberty

(Renewal criteria continued on next page)

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RENEWAL CRITERIA (CONTINUED)

For growth failure due to Prader-Willi syndrome (PWS), renewal requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- Improvement in body composition

For growth failure in children born small for gestational age (SGA), renewal requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand)
- Growth velocity of 2 cm or more compared with what was observed from the previous year or patient has not reached 50th percentile for patients predicted adult height

For growth failure associated with Turner syndrome, renewal requires ALL of the following:

- Therapy is prescribed by or in consultation with an endocrinologist
- The patient's epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand)
- Growth velocity of 2 cm or more compared with what was observed from the previous year or patient has not reached 50th percentile for patient's predicted adult height

For adult growth hormone deficiency, renewal requires:

- Therapy is prescribed by or in consultation with an endocrinologist

If yes, **approve for 12 months by GPID or GPI-14 for all strengths.**

If no, do not approve.

RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **SOMATROPIN (Omnitrope)** requires the following rule(s) be met for renewal:

A. You have ONE of the following diagnoses:

1. Pediatric growth hormone deficiency (GHD: a type of hormone disorder with low growth hormone)
2. Growth failure due to Prader-Willi syndrome (PWS: a type of gene condition)
3. Growth failure in children born small for gestational age (SGA)
4. Growth failure associated with Turner syndrome (TS: a type of gene condition)
5. Adult growth hormone deficiency

This medication will not be approved for treatment of **ANY** of the following conditions:

1. Athletic enhancement
2. Anti-aging purposes
3. Idiopathic short stature (short height due to unknown cause)

(Renewal denial text continued on next page)

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RENEWAL CRITERIA (CONTINUED)

- B. If you have pediatric growth hormone deficiency, renewal also requires:**
1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. Your epiphyses (end part of long bone) are NOT closed (confirmed by radiograph [type of imaging test] of the wrist and hand or you have not completed prepubertal growth)
 3. You meet ONE of the following:
 - a. Your annual growth velocity is 2 cm or more compared with what was observed from the previous year
 - b. Your annual growth velocity is 1 cm or more compared with what was observed from the previous year if you are near the terminal (end) phase of puberty
- C. If you have growth failure due to Prader-Willi syndrome, renewal also requires:**
1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. You have experienced improvement in body composition
- D. If you have growth failure and are a child born small for gestational age, renewal also requires:**
1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. Your epiphyses (end part of long bone) are NOT closed as confirmed by radiograph (type of imaging test) of the wrist and hand
 3. Your growth velocity is 2 cm or more compared with what was observed from the previous year and/or you have not reached 50th percentile for your predicted adult height
- E. If you have growth failure associated with Turner syndrome, renewal also requires:**
1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)
 2. Your epiphyses (end part of long bone) are NOT closed as confirmed by radiograph (type of imaging test) of the wrist and hand
 3. Your growth velocity is 2 cm or more compared with what was observed from the previous year and/or you have not reached 50th percentile for your predicted adult height
- F. If you have adult growth hormone deficiency, renewal also requires:**
1. Therapy is prescribed by or in consultation with an endocrinologist (hormone doctor)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Omnitrope.

REFERENCES

- Omnitrope [Prescribing Information]. Princeton, NJ: Sandoz, Inc.; June 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

Commercial Effective: 11/01/22

Created: 10/22

Client Approval: 10/22

P&T Approval: 04/21