UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1039-23
Program	Prior Authorization/Notification – Human Growth Hormone, Growth Stimulating Products
Medication	Human Growth Hormone: Somatropin (Genotropin®*, Humatrope®*, Norditropin®, Nutropin AQ NuSpin®*, Omnitrope®, Saizen®*, Serostim®, Zomacton®*, Zorbtive®), Skytrofa™, (lonapegsomatropin-tcgd), Sogroya®(somapacitan-beco), Ngenla™ (somatrogon-ghla) Growth Stimulating Products: Mecasermin (Increlex®)
P&T Approval Date	4/2008, 4/2009, 10/13/2009, 7/13/2010, 7/2011, 8/2012, 8/2013, 2/2014, 8/2014, 8/2015, 1/2016, 12/2016, 11/2017, 11/2018, 12/2019, 4/2020, 6/2021, 1/2022, 5/2022, 7/2022, 7/2023, 11/2023, 2/2024, 10/2024, 2/2025, 8/2025-supplemental, 9/2025, 4/2026, 6/2026
Effective Date	9/1/2026

1. **Background:**
Somatropin (Genotropin®*, Humatrope®*, Norditropin®, Nutropin AQ NuSpin®*, Omnitrope®, Saizen®*, Zomacton®*) is indicated for the treatment of pediatric patients with growth failure due to inadequate secretion of endogenous growth hormone (GH), growth hormone deficiency (GHD), short stature associated with Turner syndrome or Noonan syndrome (NS), idiopathic short stature (ISS), short-stature or growth failure in short stature homeobox-containing gene homeobox (SHOX) gene deficiency, growth failure due to Prader-Willi syndrome, short stature in children born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years of age, and chronic kidney disease (CKD) up to the time of renal transplantation., growth failure in children with chronic renal insufficiency up to the time of transplant, short bowel syndrome in patients receiving specialized nutritional support, and HIV-associated wasting. Somatropin is also indicated for replacement of endogenous GH in adults with confirmed GHD.

Ngenla™ (somatrogon-ghla), is indicated for the treatment of pediatric patients aged 3 years and older who have growth failure due to inadequate secretion of endogenous GH.

Skytrofa™ (lonapegsomatropin-tcgd) is indicated for the treatment of pediatric patients 1 year and older who weigh at least 11.5 kg and have growth failure due to inadequate secretion of endogenous GH. It is also indicated for the replacement of endogenous GH in adults with GHD.

Sogroya®(somapacitan-beco) is indicated for the treatment of pediatric patients aged 2.5 years and older who have growth failure due to inadequate secretion of endogenous GH, SGA and no catch-up growth by 2 years of age, growth failure associated with NS, and ISS. It is also indicated for the replacement of endogenous GH in adults with GHD.

Serostim® (somatropin) is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight and improve physical endurance.

Zorbtive® (somatropin) is indicated for the treatment of short bowel syndrome in adult patients receiving specialized nutritional support.

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Increlex® (mecasermin) is indicated for the treatment of growth failure in pediatric patients 2 years of age and older with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with GH gene deletion that have developed neutralizing antibodies to GH.

Coverage Information
Since short stature in the absence of defined pathology is not a sickness or injury, growth hormone is not a covered health service for these indications. The standard UnitedHealthcare Pharmacy Rider explicitly excludes coverage of growth hormone for short stature caused by heredity and not by a diagnosed medical condition.

Coverage for somatropin (Genotropin*, Humatrope*, Norditropin, Nutropin AQ NuSpin*, Omnitrope, Saizen*, Serostim, Zomacton*, Zorbtive), Ngenla, Skytrofa, Sogroya, and Increlex will be provided for members who meet the following criteria:

2. Coverage Criteria:

A. Congenital Growth Hormone Deficiency (GHD)

1. **Initial Therapy**

a. **Somatropin** will be approved based on **all** of the following criteria:

(1) Infant is < 12 months of age

-AND-

(2) Evidence of growth failure confirmed by **all** of the following:

(a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
(b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
(c) Calculated growth velocity

-AND-

(3) **One** of the following:

(a) **Both** of the following:

i. Hypothalmic-pituitary defect (e.g., ectopic posterior pituitary, empty sella, hypoplastic pituitary, major congenital malformation, optic nerve hypoplasia, tumor or irradiation)
ii. Deficiency of at least one additional pituitary hormone

-OR-

(b) **All** of the following:

i. Neonatal hypoglycemia and/or micropenis
ii. Serum GH concentration ≤ 5 µg/L in the first 28 days of life

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iii. Deficiency of at least one additional pituitary hormone
iv. Classical imaging triad (i.e., ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk)

-AND-

(4) **One** of the following is below the age and gender adjusted normal range as provided by the physician's lab:

(a) Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
(b) Insulin Growth Factor Binding Protein-3 (IGFBP-3)

-AND-

(5) Documentation that other etiologies for growth failure (e.g., celiac disease, inflammatory bowel disease, medications that slow growth, poor caloric intake/absorption, rheumatologic disease, skeletal dysplasia, thyroid dysfunction) have been ruled out

2. **Reauthorization**

a. **Somatropin** will be approved based on **both** of the following criteria:

(1) Height increase of at least 2 cm/year over the previous year documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for length/height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not attained
(b) Documentation of expected adult height goal (e.g., genetic potential)

B. Pediatric Growth Hormone Deficiency (GHD)
Note: If patient is a Transition Phase Adolescent or Adult who had childhood onset GH deficiency, utilize criteria for Transition Phase Adolescent or Adult GH Deficiency.

1. **Initial Therapy**

a. **Ngenla, Skytrofa, Sogroya, or Somatropin** will be approved based on **all** of the following criteria:

(1) Diagnosis of pediatric GH deficiency

-AND-

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(2) Evidence of growth failure confirmed by **all** of the following:

(a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
(b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
(c) Calculated growth velocity

-AND-

(3) Documentation of open epiphyses in the last 12 months

-AND-

(4) Tanner stage ≤ 4

-AND-

(5) Documentation of **both** of the following:

(a) Patient has undergone **two** of the following provocative GH stimulation tests:

i. Arginine
ii. Clonidine
iii. Glucagon
iv. Insulin
v. Levodopa

-AND-

(b) Peak GH responses to each agent is < 10 mcg/L

-AND-

(6) If patient has a history of malignancy, documentation of **one** of the following:

(a) Patient is in remission
(b) Patient has been stable for at least 12 months

-AND-

(7) Documentation that other etiologies for growth failure (e.g., celiac disease, inflammatory bowel disease, medications that slow growth, poor caloric intake/absorption, rheumatologic disease, skeletal dysplasia, thyroid dysfunction) have been ruled out

Authorization will be issued for 12 months.

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2. **Reauthorization**

a. **Ngenla, Skytrofa, Sogroya, or Somatropin** will be approved based on **both** of the following criteria:

(1) Height increase of at least 2 cm/year over the previous year documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for length/height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not attained
(b) Documentation of expected adult height goal (e.g., genetic potential)

Authorization will be issued for 12 months.

C. Transition Phase Adolescent Patients
Note: Use these criteria for patients diagnosed with GHD during the transition period from puberty to adulthood (the period from mid to late teens until 6 to 7 years after achievement of adult height).

1. **Initial Therapy**

a. **Skytrofa, Sogroya, or Somatropin** will be approved based on **all** of the following criteria:

(1) **One** of the following:

(a) Genetic mutation

-OR-

(b) Deficiency of **three** of the following anterior pituitary hormones:

i. ACTH
ii. TSH
iii. Prolactin
iv. FSH/LH

-OR-

(c) Irreversible structural hypothalamic-pituitary disease

-OR-

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(d) Panhypopituitarism

-AND-

(2) **One** of the following:

(a) IGF-1 level is below the age and gender adjusted normal range as provided by the physician's lab

-OR-

(b) **Both** of the following:

i. Patient has undergone **one** of the following GH stimulation tests after discontinuation of therapy for at least 1 month:
- Insulin tolerance test (ITT)
- GH-releasing hormone-arginine test (GHRH+ARG)
- Glucagon stimulation test (GST)
- Macimorelin

-AND-

ii. **One** of the following peak GH values:
- ITT ≤ 5.1 µg/L
- GHRH+ARG ≤ 11 µg/L
- Glucagon ≤ 3 µg/L
- Macimorelin ≤ 2.8 ng/mL

-AND-

(3) Documentation that other etiologies for growth failure (e.g., celiac disease, inflammatory bowel disease, medications that slow growth, poor caloric intake/absorption, rheumatologic disease, skeletal dysplasia, thyroid dysfunction) have been ruled out

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Skytrofa, Sogroya, or Somatropin** will be approved based on the following criterion**:**

(1) Documentation of positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 and IGFBP-3 levels)

Authorization will be issued for 12 months.

D. Adult Growth Hormone Deficiency

1. **Initial Therapy**

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a. **Skytrofa, Somatropin, or Sogroya** will be approved based on **all** of the following criteria:

(1) Diagnosis of adult growth hormone deficiency (GHD) as a result of **one** of the following:

(a) Known hypothalamic or pituitary disease
(b) Panhypopituitarism
(c) History of GHD in childhood

-AND-

(2) **One** of the following:

(a) IGF-1 level is below the age and gender adjusted normal range as provided by the physician's lab

-OR-

(b) **All** of the following:

i. Patient does not have a low IGF-1

-AND-

ii. Patient has undergone **one** of the following GH stimulation tests:
- GH-releasing hormone-arginine test (GHRH+ARG)
- Glucagon stimulation test (GST)
- Macimorelin

-AND-

iii. **One** of the following peak GH values:
- GHRH+ARG ≤ 11 µg/L
- Glucagon ≤ 3 ng/mL
- Macimorelin ≤ 2.8 ng/mL

-AND-

(3) **One** of the following:

(a) Diagnosis of panhypopituitarism

-OR-

(b) Other diagnosis **and** not used in combination with the following:

i. Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]

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ii. Androgens [e.g., Delatestryl (testoseterone enanthate), Depo Testosterone (testosterone cypionate)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Skytrofa, Somatropin, or Sogroya** will be approved based on **both** of the following criteria:

(1) Documentation of IGF-1 within the past 12 months

-AND-

(2) **One** of the following:

(a) Diagnosis of panhypopituitarism

-OR-

(b) Other diagnosis **and** not used in combination with the following:

i. Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
ii. Androgens [e.g., Delatestryl (testoseterone enanthate), Depo-Testosterone (testosterone cypionate)]

Authorization will be issued for 12 months.

E. Prader-Willi Syndrome

1. **Initial Therapy**

a. **Somatropin** will be approved based on **all** of the following criteria:

(1) Diagnosis of Prader-Willi Syndrome

-AND-

(2) Diagnosis confirmed by genetic testing

-AND-

(3) **One** of the following:

(a) **Both** of the following:

i. Patient is < 18 years of age

-AND-

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ii. Evidence of growth failure confirmed by **all** of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
- Calculated growth velocity

-OR-

(b) Patient is > 18 years of age

(4) Patient does not have **any** of the following:

(a) Active malignancy
(b) Severe obesity (weight >225 percent of ideal body weight)
(c) Severe respiratory impairment

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Somatropin** will be approved based on the following criterion:

(1) **One** of the following:

(a) **All** of the following:

i. Patient is < 18 years of age

-AND-

ii. Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth charts for length/height for age and gender

-AND-

iii. **Both** of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

-OR-

(b) **Both** of the following:

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i. Patient is ≥ 18 years of age

-AND-

ii. Documentation of positive response to therapy (e.g., reduction in fat mass, increase in lean body mass, improved strength and exercise tolerance)

Authorization will be issued for 12 months.

F. Growth Failure in Children Small for Gestational Age (SGA)

1. **Initial Therapy**

a. **Sogroya or Somatropin** will be approved based on **all** of the following criteria:

(1) Diagnosis of growth failure associated with SGA

-AND-

(2) Diagnosis confirmed by **all** of the following:

(a) **Both** of the following:

i. Growth charts for length/height and weight for gestational age and gender at birth

-AND-

ii. Documentation that birth length/height and/or weight ≥ 2 SD below mean for gestational age

-AND-

(b) Infant growth charts for length/height and weight for age and gender between birth and 24 to 36 months of age do not show evidence of catch-up growth in length/height and/or weight (i.e., length/height or weight remained ≥ 2 SD below mean for age and gender from birth to age 2 to 3)

-AND-

(c) Documentation that current length/height and/or weight remains ≥ 2 SD below mean for age and gender

-AND-

(d) Calculated growth velocity

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-AND-

(3) Documentation that other etiologies for failure to catch up in weight and/or height (e.g., celiac disease, inflammatory bowel disease, medications that slow growth, poor caloric intake/absorption, rheumatologic disease, skeletal dysplasia, thyroid dysfunction) have been ruled out

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Sogroya or Somatropin** will be approved based on **both** of the following criteria:

(1) Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for length/height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not attained
(b) Documentation of expected adult height goal

Authorization will be issued for 12 months.

G. Turner Syndrome or Noonan Syndrome

1. **Initial Therapy**

a. **Sogroya or Somatropin** will be approved based on **all** of the following criteria:

(1) **One** of the following:

(a) If request is for somatropin, **both** of the following:

i. Diagnosis of Turner Syndrome
ii. Diagnosis confirmed by genetic testing

-OR-

(b) If request is for somatropin or Sogroya, **both** of the following:

i. Diagnosis of Noonan Syndrome
ii. Diagnosis confirmed by the presence of clinical features consistent

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with Noonan Syndrome (e.g., distinct facial features such as high forehead, hypertelorism, down slanting palpebral fissures with high arched eyebrows, epicanthic folds, full upper lip with a depressed nasal bridge, low set ears, blue irises, ptosis and neck webbing, pulmonary valve stenosis, hypertrophic cardiomyopathy, pectus carinatum/excavatum, mild developmental delay, cryptorchidism, lymphatic dysplasia)

-AND-

(2) Documentation of **all** of the following:

(a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
(b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
(c) Calculated growth velocity

-AND-

(3) Documentation of open epiphyses in the last 12 months

-AND-

(4) Tanner staging less than equal to 4

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Sogroya or Somatropin** will be approved based on **both** of the following criteria:

(1) Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not attained
(b) Documentation of expected adult height goal

Authorization will be issued for 12 months.

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H. Short-Stature Homeobox (SHOX) Gene Deficiency

1. **Initial Therapy**

   a. **Somatropin** will be approved based on **all** of the following criteria:

      (1) Diagnosis of short-stature homeobox (SHOX) gene deficiency confirmed by genetic testing

      -AND-

      (2) Documentation of **all** of the following:

         (a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
         (b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
         (c) Calculated growth velocity

      -AND-

      (3) Documentation of open epiphyses in the last 12 months

      -AND-

      (4) Tanner stage ≤ 4

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Somatropin** will be approved based on **both** of the following criteria:

      (1) Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

         (a) Previous length/height and date obtained
         (b) Current length/height and date obtained
         (c) Calculated growth velocity
         (d) Growth chart for height for age and gender

      -AND-

      (2) **Both** of the following:

         (a) Expected adult height not attained
         (b) Documentation of expected adult height goal

      Authorization will be issued for 12 months.

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I. Growth Failure associated with Chronic Renal Insufficiency

1. **Initial Therapy**

   a. **Somatropin** will be approved based on **all** of the following criteria:

      (1) Diagnosis of chronic renal insufficiency

      -AND-

      (2) Patient has not yet had a renal transplant

      -AND-

      (3) Documentation of **all** of the following:

         (a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
         (b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
         (c) Calculated growth velocity

      -AND-

      (4) Documentation of open epiphyses in the last 12 months

      -AND-

      (5) Tanner stage ≤ 4

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Somatropin** will be approved based on **all** of the following criteria.

      (1) Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

         (a) Previous length/height and date obtained
         (b) Current length/height and date obtained
         (c) Calculated growth velocity
         (d) Growth chart for height for age and gender

      -AND-

      (2) **Both** of the following:

         (a) Expected adult height not attained
         (b) Documentation of expected adult height goal

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-AND-

(3) Patient has not yet had a renal transplant

Authorization will be issued for 12 months.

J. Human Immunodeficiency Virus (HIV)-Associated Cachexia (Serostim only)

1. **Initial Therapy**

a. **Serostim** will be approved based on **all** of the following criteria:

(1) Diagnosis of HIV-associated wasting syndrome or cachexia

-AND-

(2) Involuntary weight loss of ≥10%

-AND-

(3) **One** of the following:

(a) Chronic diarrhea (2 loose stools daily for more than 30 days)

-OR-

(b) **Both** of the following:

i. Chronic weakness
ii. Fever

-AND-

(4) Symptoms lasting ≥ 30 days (intermittent or constant)

-AND-

(5) Absence of a concurrent condition other than HIV infection that may cause these findings (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy except for Kaposi's sarcoma limited to skin or mucous membranes)

-AND-

(6) A nutritional evaluation has been completed since onset of wasting first occurred

-AND-

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(7) Patient's anti-retroviral therapy has been optimized to decrease the viral load

Authorization will be issued for 3 months.

2. **Reauthorization**

a. **Serostim** will be approved based on **both** of the following criteria:

(1) Evidence of positive response to therapy (i.e., ≥ 2% increase in body weight and/or body cell mass)

-AND-

(2) **One** of the following targets or goals has not been achieved:

(a) Weight
(b) Body cell mass (BCM)
(c) Body mass index (BMI)

Authorization will be issued for 6 months.

K. Short Bowel Syndrome (Zorbtive only)

1. **Zorbtive** will be approved based on **all** of the following criteria:

a. Diagnosis of Short Bowel Syndrome

-AND-

b. Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements)

-AND-

c. Patient has not previously received 4 weeks of treatment with Zorbtive

Authorization will be issued for 4 weeks.

Note: Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.

L. Idiopathic Short Stature (for the state of Maryland only)

1. **Initial Therapy**

a. **Sogroya or Somatropin** will be approved based on **all** of the following criteria:

(1) Diagnosis of idiopathic short stature

-AND-

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(2) Documentation of growth failure as evidenced by **all** of the following:

(a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
(b) Documentation of length/height and weight for age and gender including percentile and/or standard deviation scores
(c) Calculated growth velocity

-AND-

(3) Predicted height < 5'3" for boys or < 4'11" for girls

-AND-

(4) Documentation that growth hormone deficiency has been ruled out by **both** of the following:

(a) Patient has undergone **two** of the following provocative growth hormone (GH) stimulation tests:

i. Arginine
ii. Clonidine
iii. Glucagon
iv. Insulin
v. Levodopa

-AND-

(b) GH responses to each agent ≥ 10 mcg/L

-AND-

(5) Documentation that skeletal dysplasia has been ruled out by at least **one** of the following:

(a) Skeletal measurements
(b) Skeletal survey

-AND-

(6) Documentation that all other causes associated with short stature have been ruled out (e.g., genetic conditions associated with short stature, rapid tempo puberty, precocious puberty, celiac disease, inflammatory bowel disease, renal failure, hepatic failure, rheumatoid arthritis, systemic lupus, etc.)

-AND-

(7) Documentation of open epiphyses in the last 12 months

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-AND-

(8) Tanner stage ≤ 4

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Sogroya or Somatropin** will be approved based on **both** of the following criteria:

(1) Height increase at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not attained
(b) Documentation of expected adult height goal

Authorization will be issued for 12 months.

M. Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion (Increlex only)

1. **Initial Therapy**

a. **Increlex** will be approved based on **all** of the following criteria:

(1) Diagnosis of severe primary IGF-1 deficiency (PIGFD)

-AND-

(2) Documentation of height below -3.0 SD mean for age and gender

-AND-

(3) Documentation of IGF-1 below -3.0 SD mean for age and gender

-AND-

(4) Other causes of low IGF-I levels have been ruled out (e.g., growth hormone deficiency, undernutrition, hepatic disease)

-AND-

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(5) Documentation of **both** of the following:

(a) Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
(b) Calculated growth velocity

-AND-

(6) **One** of the following:

(a) Patient is unresponsive to a trial of growth hormone therapy

-OR-

(b) Documentation of **one** of the following:

i. Very low or undetectable level of GHBP
ii. Very low or undetectable level of *GHR* mutations known to cause Laron syndrome/GH insensitivity syndrome
iii. *GH1* gene deletion (GHD type 1A)
iv. GH-neutralizing antibodies
v. *STT5b* gene mutation
vi. *IGF-1* gene deletion or mutation

-AND-

(7) Patient will not be treated with concurrent growth hormone therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Increlex** will be approved based on **all** of the following criteria:

(1) Height increase of at least 2 cm/year over the previous year of treatment as documented by **all** of the following:

(a) Previous length/height and date obtained
(b) Current length/height and date obtained
(c) Calculated growth velocity
(d) Growth chart for height for age and gender

-AND-

(2) **Both** of the following:

(a) Expected adult height not obtained
(b) Documentation of expected adult height goal

-AND-

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(3) Patient is not treated with concurrent growth hormone therapy

Authorization will be issued for 12 months.

***** Genotropin, Humatrope, Nutropin, Saizen, and Zomacton are typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

Essential versus Nonessential Use
The Patient Protection and Affordable Care Act (PPACA) of 2010 includes a mandate that prohibits annual dollar maximum limits for "essential" benefits. A strict definition of "essential" was not provided in PPACA or in federal health care regulations published as of the date this program was revised. UnitedHealthcare defines an "essential" use of growth hormone as therapy to treat a deficiency as part of chronic disease management. Other uses such as replacement therapy in a disorder where a deficiency is not noted are considered "nonessential."

This information applies to groups with benefit caps in place for growth hormone therapy. If the diagnosis is considered an essential use of the medication, the cap will not apply. For these cases, an override for the cap amount will be entered at the same time the authorization (if criteria met) is entered for the medication. If the diagnosis is a nonessential use of the medication, then only the authorization for the medication will be entered.

Diagnosis	
Pediatric growth hormone deficiency	Essential
Growth failure in children small for gestational age	Nonessential
Growth failure due to chronic renal insufficiency	Nonessential
Growth failure due to Turner Syndrome	Nonessential
Growth failure due to Noonan Syndrome	Nonessential
Growth failure due to short-stature homeobox (SHOX) gene deficiency	Nonessential
Prader-Willi Syndrome	Nonessential
Adult growth hormone deficiency	Essential
Transition phase adolescent patients	Essential
HIV-associated wasting syndrome/cachexia	Essential
Short bowel syndrome	Essential
Severe primary IGF-1 deficiency	Essential
Idiopathic short stature (not currently covered per criteria)	Nonessential

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

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Program	Prior Authorization/Notification – Human Growth Hormone, Growth Stimulating Products
Change Control	
8/2013	Annual review with clarification of transitional phase adolescent and SGA criteria. Updated formatting and references.
2/2014	Modified bone age and height requirement to align with Lawson-Wilkins pediatric guidelines. Added correct dosing to be utilized per PI to both adult and children. Added not to be used in combination with androgens and aromatase inhibitors to adult criteria.
8/2014	Added concomitant use requirement to Increlex reauthorization criteria.
8/2015	Added requirement for SL dosing maximum to pediatric GHD, adult GHD, transitional, and ISS. Removed Tev-Tropin and added Zomacton.
1/2016	Removal of SL dosing maximum criterion reference from 8/2015 update.
12/2016	Updated criteria for diagnosis of pediatric GH deficiency. Updated references.
11/2017	Annual review. Updated references.
11/2018	Annual review. Added macrilen (macimorelin) as an option for the diagnosis of adult growth hormone deficiency and updated references.
12/2019	Annual review. Updated bone age requirement and references.
4/2020	Added requirement for state of California.
6/2021	Annual review. No change of clinical criteria. Updated references.
1/2022	Removed Nutropin AQ which is no longer commercially available. Added coverage criteria for new product, Skytrofa. Updated

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	background and references.
5/2022	Updated requirement for idiopathic short stature to only include Maryland.
7/2022	Removed exclusion notation from Norditropin.
7/2023	Annual review. Updated references.
11/2023	Added coverage criteria for Ngenla and Sogroya. Removed Skytrofa and added Sogroya to exclusion footnote. Updated background and references.
2/2024	Removed Omnitrope from exclusion footnote.
10/2024	Added Nutropin to exclusion footnote.
2/2025	Updated authorization criteria to align with the most current treatment guidelines for all indications. Removed dosing limitations for all indications. Removed Nordiflex from program which has been discontinued. Updated background and references.
8/2025	Supplemental update to include levodopa as acceptable GH stimulation test for pediatric GHD.
9/2025	Added adult GHD as covered indication for Skytrofa. Updated SGA initial authorization criteria. Updated ISS criteria. Updated background and references.
4/2026	Added SGA, NS, and ISS as covered indications for Sogroya. Removed Ngenla, Skytrofa, and Sogroya from congenital GHD section. Within congenital GHD, pediatric GHD, adolescent GHD, and SGA sections, added requirements that all other etiologies for growth failure have been ruled out. Updated background and references.
6/2026	Added GHD in transition phase adolescent patients as covered indication for Skytrofa and Sogroya. Removed Sogroya from exclusion footnote. Updated references.

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