Pharmacy Drug Policy Checklist

POLICY NAME	Egrifta SV (tesamorelin acetate)	POLICY #	1943P

Criteria

Coverage Criteria

- ☐ Diagnosis of human immunodeficiency virus (HIV)
- ☐ Documented presence of abdominal lipodystrophy (abnormal fat distribution)
- ☐ Documentation which indicates the sole purpose of treatment is not weight loss
- ☐ Documented compliance with antiretroviral therapy (ART; such as Biktarvy, Complera, etc)

Approval Criteria

- ☐ Initial: 12 months
- ☐ Renewal: 12 months with demonstrated a clear clinical improvement from baseline that is supported by a waist circumference or CT scan CPT Codes HCPCS Codes