Pharmacy Drug Policy Checklist

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

Criteria

Coverage Criteria

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

Approval Criteria

- ☐ **2.1** Initial: 12 months
- ☐ **2.2** 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