

**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