



## PRIOR AUTHORIZATION POLICY

- POLICY:** Growth Disorders – Sogroya Prior Authorization Policy
- Sogroya® (somapacitan-beco subcutaneous injection – Novo Nordisk)

**REVIEW DATE:** 06/18/2025; selected revision 08/13/2025 and 04/08/2026

### **INSTRUCTIONS FOR USE**

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

## **CIGNA NATIONAL FORMULARY COVERAGE:**

### **OVERVIEW**

Sogroya, a long-acting human growth hormone (hGH) analog, is indicated for the treatment of pediatric patients  $\geq 2.5$  years of age who have growth failure due to inadequate secretion of growth hormone (GH), short stature born small for gestational age (SGA) and with no catch-up growth by 2 years of age, growth failure associated with Noonan syndrome, and idiopathic short stature.<sup>1</sup> Sogroya is also indicated for the replacement of endogenous GH in adults with GH deficiency (GHD).

### **Disease Overview**

#### *GHD in Children and Adolescents*

Sogroya is a hGH analog.<sup>1</sup> In children with GHD, somatropin is effective for increasing final adult height.<sup>2</sup> Somatropin therapy is recommended to normalize adult height and avoid extreme shortness in children and adolescents with GHD.<sup>2</sup> In addition to congenital causes, hypopituitarism may also be caused by radiation therapy;

somatropin may be used to improve final height of children who have undergone radiation.<sup>3,4</sup>

#### *GHD in Adults or Transition Adolescents*

Somatropin is indicated for the replacement of endogenous GH in adults with GH, which may present in adults or children as GHD.<sup>11</sup> Patients with other anterior pituitary hormone deficiencies are likely to have GHD. In adults, the diagnosis of GHD usually is made in patients with signs and symptoms of hypothalamic-pituitary disease (endocrine, structural, and/or genetic causes); those who have received cranial irradiation or tumor treatment; or those with traumatic brain injury or subarachnoid hemorrhage.<sup>11,12</sup> Onset may be in adulthood or childhood. In childhood, the goal of somatropin therapy is primarily for statural growth. When final adult height is attained, somatropin therapy is no longer required for statural growth. Transition is used to describe the period in adolescence after growth is completed and the need for continued replacement into adulthood is assessed. Confirmatory GH stimulation testing may not be required in patients, such as those with congenital/genetic GHD or multiple pituitary hormone deficiencies. When persistent GHD is documented after completion of adult height, somatropin therapy should be continued to attain full skeletal and muscle maturation during the transition period from childhood to adulthood.<sup>11</sup> In adults with GHD, somatropin replacement therapy improves abnormalities in substrate metabolism, body composition, and physical and psychosocial function.<sup>11,12</sup> GH is not approved by the FDA for the treatment of other conditions in adults who may have a low GH response to GH provocative testing (such as obesity, aging, or depression) or to improve athletic performance.<sup>3,5</sup>

Macrilen (macimorelin oral solution) was the most recently approved test for the diagnosis of adult GHD. Patients in the pivotal trial were 18 to 66 years of age and the BMI ranged from 16 to 40 kg/m<sup>2</sup>.<sup>26</sup> Safety and diagnostic performance have not been established in patients with BMI > 40 kg/m<sup>2</sup>. Clinical studies established that a maximally stimulated serum growth hormone level of < 2.8 ng/mL (i.e., at the 30, 45, 60, and 90 minute time points) after Macrilen administration confirms the presence of adult GHD. Novo Nordisk no longer commercializes Macrilen. As of May 2023, Aeterna Zentaris/Cosciens Biopharma regained the rights to macimorelin in the United States and is engaged in business development efforts to secure a new development and commercialization partner.<sup>27</sup>

#### **Guidelines**

A consensus statement from international experts was recently published (2025) regarding long-acting GH therapy.<sup>28</sup> The authors note that lonapegsomatropin, somapacitan, and somatogon have all demonstrated noninferiority to daily somatropin for efficacy (i.e., annualized height velocity) in pediatric GHD. They also state that the safety profile of long-acting products is comparable to that of daily somatropin. It is noted that given the unique pharmacokinetic and pharmacodynamic profile and molecular weight of each formulation, the weight-based dosing calculation is different for each product and direct milligram dose comparisons are not appropriate. Some guidelines do not specifically address Sogroya. Neither the Pediatric Endocrine Society guidelines for children and adolescents with GH deficiency<sup>2</sup> (2016) nor the GH Research Society guidelines on children with short

stature<sup>15</sup> (2019) recommend a specific GH product for GHD. Both publications note that newer long-acting GH preparations may reduce the frequency of injections.

The American Association of Clinical Endocrinologists and the American College of Endocrinology guidelines for management of GHD in adults and patients transitioning from pediatric to adult care<sup>16</sup> (2019) also do not prefer one GH agent over another. These guidelines state that when the clinician is suspicious of adult GHD, establishing a diagnosis is essential before replacement with GH. Adult GHD is associated with numerous adverse metabolic abnormalities (abdominal obesity, reduced lean body mass, increased peripheral insulin resistance, impaired cardiac performance) which may contribute to increased cardiovascular morbidity and mortality.

### **Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in Children or Adolescents**

Sogroya is indicated for the treatment of pediatric patients  $\geq 2.5$  years of age with idiopathic short stature (ISS).<sup>1</sup> The inclusion criteria for Sogroya in the pivotal study for this diagnosis included patients with a height at least 2.5 standard deviation (SD) below the mean for chronological age and sex and one normal GH secretion (GH peak  $> 7$  ng/mL) during GH stimulation testing.<sup>30</sup> The Pediatric Endocrine Society guidelines (2016) recommend that the decision to treat idiopathic short stature with somatropin be made on a case-by-case basis after assessing physical and psychological burdens, and discussion of risks and benefits.<sup>2</sup> They recommend against the routine use of somatropin in every child with height SDS  $\leq -2.25$ . In one consensus statement on children with idiopathic short stature from the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop (2008), it was felt that the optimal age for initiating treatment is 5 years to early puberty.<sup>31</sup>

### **Noonan Syndrome and Short Stature in Children or Adolescents**

Sogroya is indicated for the treatment of pediatric patients  $\geq 2.5$  years of age with growth failure associated with Noonan syndrome.<sup>1</sup> Not all patients with Noonan syndrome have short stature; some will achieve a normal adult height without treatment. The diagnosis of Noonan is established with suggestive findings and a heterozygous pathogenic variant in BRAF, KRAS, MAP2K1, MRAS, NRAS, PTPN11, RAF1, RASA2, RIT1, RRAS2, SOS1, SOS2 or either a heterozygous variant or biallelic pathogenic variants in LZTR1.<sup>29</sup> The inclusion criteria for Sogroya in the pivotal study for this diagnosis included prepubertal patients with an impaired height (at least 2.0 SD below the mean) for chronological age and sex.<sup>32</sup>

### **Small for Gestational Age (SGA)**

Sogroya is indicated for the treatment of pediatric patients  $\geq 2.5$  years of age born SGA with no catch-up growth by 2 years of age.<sup>1</sup> The inclusion criteria for Sogroya in the pivotal study for this diagnosis included prepubertal children born SGA (birth length and/or weight  $< -2.0$  standard deviation score [SDS]) with no catch-up growth. Additionally, all patients had to have impaired height ( $\leq 2.5$  SDS), impaired height velocity below the 50<sup>th</sup> percentile for age/sex, and body mass index below the 95<sup>th</sup> percentile.<sup>33</sup>

## **POLICY STATEMENT**

Prior Authorization is recommended for prescription benefit coverage of Sogroya. All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Sogroya as well as monitoring required for adverse events and long-term efficacy, initial approval requires the medication to be prescribed by or in consultation with a physician who specializes in the condition being treated. Human growth hormone is FDA-approved for treatment of a limited number of conditions. The FDA has not approved the use of human growth hormone as therapy for anti-aging, longevity, cosmetic or performance enhancement. Federal law prohibits the dispensing of human growth hormone for non-approved purposes. A pharmacy's failure to comply with that law could result in significant criminal penalties to the pharmacy and its employees. Accordingly, a pharmacy may decline to dispense prescriptions for human growth hormone when written by a physician or other authorized prescribers who they believe may be involved in or affiliated with the fields of anti-aging, longevity, rejuvenation, cosmetic, performance enhancement, or sports medicine.

**Documentation:** Documentation is required for use of Sogroya as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information. For patient cases in which documentation is required, if this documentation has been previously received upon a prior coverage review, the documentation requirement is considered to be met.

• **Sogroya® (somapacitan-beco subcutaneous injection - Novo Nordisk) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

### **FDA-Approved Indications**

#### **1. Growth Hormone Deficiency in a Child or Adolescent (≥ 2.5 years of age).**

Approve for 1 year if the patient meets ONE the following (A or B):

**A) Initial Therapy with any Growth Hormone Agent.** Approve if the patient meets ONE of the following (i, ii, iii, iv, or v):

**i.** Patient meets BOTH of the following (a and b):

**a)** Patient meets ONE of the following [(1) or (2)]:

**(1)** Patient has had at least two growth hormone stimulation tests performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the peak growth hormone response to both tests are < 10 ng/mL; OR

**(2)** Patient meets BOTH of the following criteria [(a) and (b)]:

**(a)** Patient has had at least one growth hormone stimulation test performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon

AND the peak growth hormone response to at least one test is < 10 ng/mL; AND

**(b)** Patient has at least one risk factor for growth hormone deficiency; AND

Note: Examples of at least one risk factor for growth hormone deficiency includes: the height for age curve has deviated downward across two major height percentiles (e.g., from above the 25<sup>th</sup> percentile to below the 10<sup>th</sup> percentile); the child's growth rate is less than the expected normal growth rate based on age and gender; low insulin-like growth factor (IGF)-1 and/or IGFBP-3 levels; the child has a very low peak growth hormone level on provocative testing as defined by the prescribing physician; the child's growth velocity is less than the 10<sup>th</sup> percentile for age and gender (height velocity percentile is NOT the same as height-for-age percentile); the patient is status post craniopharyngioma resection; the patient has optic nerve hypoplasia; the patient has a growth hormone gene deletion; AND

**b)** The medication has been prescribed by or in consultation with an endocrinologist; OR

**ii.** Patient has undergone brain radiation or tumor resection AND meets BOTH of the following (a and b):

**a)** Patient meets at least ONE of the following [(1) or (2)]:

**(1)** Patient meets BOTH of the following [(i) and (ii)]:

**(i)** Patient has had at least one growth hormone stimulation test performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND

**(ii)** The peak growth hormone response to at least one test is < 10 ng/mL; OR

**(2)** Patient has a deficiency in at least one other pituitary hormone (i.e., adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin [luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency], or prolactin); AND

**b)** The medication has been prescribed by or in consultation with an endocrinologist; OR

**iii.** Patient has congenital hypopituitarism AND meets BOTH of the following (a and b):

**a)** Patient meets at least ONE of the following [(1), (2), or (3)]:

**(1)** Patient meets BOTH of the following [(i) and (ii)]:

**(i)** Patient has had at least one growth hormone stimulation test performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND

**(ii)** The peak growth hormone response to at least one test is < 10 ng/mL; OR

**(2)** Patient has a deficiency in at least one other pituitary hormone (i.e., adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin [luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency], or prolactin); OR

- (3) Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk; AND
    - b) The medication has been prescribed by or in consultation with an endocrinologist; OR
  - iv. Patient has multiple pituitary hormone deficiencies and meets BOTH of the following (a and b):
    - Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency.
    - a) Patient meets at least ONE of the following [(1) or (2)]:
      - (1) Patient has three or more of the following pituitary hormone deficiencies: somatotropin (growth hormone), adrenocorticotrophic hormone, thyroid-stimulating hormone, gonadotropin (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and prolactin; OR
      - (2) Patient meets BOTH of the following [(i) and (ii)]
        - (i) Patient had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon; AND
        - (ii) The peak growth hormone response to at least one test is < 10 ng/mL; AND
    - b) The medication has been prescribed by or in consultation with an endocrinologist; OR
  - v. Patient has had a hypophysectomy (surgical removal of pituitary gland); OR
- B) Patient is Currently Receiving Sogroya or is switching to Sogroya from another Growth Hormone Agent (Patient has been established on either therapy for  $\geq$  10 months). Approve if the patient meets ONE of the following (i, ii, or iii):**
- i. Patient is < 12 years of age: Patient's height has increased by  $\geq$  2 cm/year in the most recent year; OR
  - ii. Patient is  $\geq$  12 years of age and < 18 years of age: Patient meets BOTH of the following (a and b):
    - a) Patient's height has increased by  $\geq$  2 cm/year in the most recent year; AND
    - b) Patient's epiphyses are open; OR
  - iii. Patient is  $\geq$  18 years of age. Patient meets ALL of the following (a, b, and c):
    - a) Patient's height has increased by  $\geq$  2 cm/year in the most recent year; AND
    - b) Patient's epiphyses are open; AND
    - c) Mid-parental height has not been attained.
      - Note: Mid-parental height is the father's height plus the mother's height divided by 2, plus 2.5 inches if male or minus 2.5 inches if female.
      - Note: Adolescents and young adults with childhood onset growth hormone deficiency who have completed linear growth may continue receiving Sogroya therapy as a transition adolescent or as an adult. See criteria for Growth Hormone Deficiency in an adult or transition adolescent.

**2. Growth Hormone Deficiency in an Adult or Transition Adolescent.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):

**A)** The endocrinologist must certify that growth hormone therapy is not being prescribed for anti-aging therapy or to enhance athletic ability or for body building; AND

**B)** Patient must have a diagnosis of growth hormone deficiency that is ONE of the following (i or ii): **[documentation required for all elements]**

**i.** Childhood onset; OR

**ii.** Adult onset that results from one of the following: growth hormone deficiency alone or multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease, hypothalamic disease, pituitary surgery, cranial radiation therapy, tumor treatment, traumatic brain injury, or subarachnoid hemorrhage; AND

**C)** Patient meets at least ONE of the following (i, ii, or iii):

**i.** Patient (adult or transition adolescent) has known perinatal insults OR congenital or genetic defects; **[documentation required]** OR

**ii.** Patient meets ALL of the following (a, b, and c):

**a)** Patient (adult onset or transition adolescent) has or had three or more of the following pituitary hormone deficiencies prior to hormone replacement therapy (if hormone therapy is required): Adrenocorticotrophic hormone, thyroid-stimulation hormone, gonadotropin deficiency (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and prolactin **[documentation required]**; AND

**b)** The age and gender adjusted serum insulin-like growth factor-1 is or was below the lower limit of the normal reference range for the reporting laboratory **[documentation required]**, prior to growth hormone therapy; AND

**c)** Other causes of low serum insulin-like growth factor-1 have been excluded (e.g., malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy); OR

**iii.** Patient meets at least ONE of the following (a or b):

**a)** Adult. Patient has had a negative response to at least ONE of the following standard growth hormone stimulation tests (1, 2, 3, 4, 5, or 6) **[documentation required for all elements]**:

Note: If the patient has had a previous trial of an arginine test with a peak response of  $\leq 0.4$  mcg/L, this would meet the criteria for a negative response to a growth hormone stimulation test.

**(1)** Insulin tolerance test (obtaining at least 3 growth hormone levels in at least a 60 minute timeframe [not including a level at timeframe zero], with adequate hypoglycemia being achieved) with peak response  $\leq 5.0$  mcg/L; OR

**(2)** Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response  $\leq 3.0$  mcg/L AND the patient's body mass index (BMI) is  $< 25$  kg/m<sup>2</sup>; OR

- (3) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response  $\leq 3.0$  mcg/L AND the patient's BMI is  $\geq 25$  kg/m<sup>2</sup> and  $\leq 30$  kg/m<sup>2</sup> with, according to the prescriber, a high pretest probability of growth hormone deficiency; OR
  - (4) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response  $\leq 1.0$  mcg/L AND the patient's BMI is  $\geq 25$  kg/m<sup>2</sup> and  $\leq 30$  kg/m<sup>2</sup> with, according to the prescriber, a low pretest probability of growth hormone deficiency; OR
  - (5) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response  $\leq 1.0$  mcg/L AND the patient's BMI is  $> 30$  kg/m<sup>2</sup>; OR
  - (6) Macrilen (macimorelin oral solution) test (obtaining at least 4 growth hormone levels in at least a 90 minute timeframe [not including a level at timeframe zero]) with peak responses  $< 2.8$  ng/mL (2.8 mcg/L) AND the patient's BMI is  $\leq 40$  kg/m<sup>2</sup>; OR  
Note: The following formula can be used to calculate BMI: BMI equals body weight in kg divided by height meters squared (m<sup>2</sup>) [i.e., BMI = kg/m<sup>2</sup>]
- b) Transition adolescent. Patient meets BOTH of the following (1 and 2):  
**[documentation required for all elements]:**  
Note: The transition period is the time from late puberty to establishment of adult muscle and bone composition, and encompasses attainment of adult height.  
Note: If the patient has had a trial of a Macrilen test with a peak response of  $< 2.8$  ng/mL (mcg/L), this would meet the criteria for a negative response to a growth hormone stimulation test.
- (1) Patient has been off growth hormone therapy for at least 1 month before retesting with a growth hormone stimulation test; AND
  - (2) Patient meets at least ONE of the following responses to growth hormone stimulation testing (i, ii, iii, iv, v or vi):
    - (i) Insulin tolerance test (obtaining at least 3 growth hormone levels in at least a 60 minute timeframe [not including a level at timeframe zero], with adequate hypoglycemia being achieved) with peak response  $\leq 5.0$  mcg/L; OR
    - (ii) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response  $\leq 3.0$  mcg/L AND the patient's body mass index (BMI) is  $< 25$  kg/m<sup>2</sup>; OR
    - (iii) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response of  $\leq 3.0$  mcg/L AND the patient's BMI is  $\geq 25$  kg/m<sup>2</sup> and  $\leq 30$  kg/m<sup>2</sup> with,

according to the prescriber, a high pretest probability of growth hormone deficiency; OR

- (iv) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with a peak response  $\leq 1.0$  mcg/L AND the patient's BMI is  $\geq 25$  kg/m<sup>2</sup> and  $\leq 30$  kg/m<sup>2</sup> with, according to the prescriber, a low pretest probability of growth hormone deficiency; OR
- (v) Glucagon stimulation test (obtaining at least 3 growth hormone levels in at least 180 minute timeframe [not including a level at timeframe zero]) with peak response  $\leq 1.0$  mcg/L AND the patient's BMI is  $> 30$  kg/m<sup>2</sup>; OR
- (vi) If both the insulin tolerance test AND glucagon stimulation test are contraindicated, the arginine test can be used (obtaining at least 3 growth hormone levels in at least 120 minute timeframe [not including a level at timeframe zero]) with a peak response  $\leq 0.4$  mcg/L; AND

**D)** The medication was prescribed by or in consultation with an endocrinologist.

**3. Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent.** Approve for the duration noted if the patient meets at least ONE of the following (A or B):

**A) Initial therapy with any Growth Hormone Agent.** Approve for 6 months if the patient meets ALL of the following (i, ii, iii, iv, v, vi, and vii):

- i.** Patient is  $\geq 5$  years of age; AND
- ii.** Patient's baseline height is  $\leq 1.2$  percentile or a standard deviation score (SDS)  $\leq -2.25$  for age and gender; AND
- iii.** Patient's growth (height) velocity meets at least ONE of the following (a or b):
  - a)** Patient has a growth rate  $< 4$  cm/year; OR
  - b)** Patient's growth (height) velocity is less than the 10th percentile for age and gender based on at least 6 months of growth data; AND

Note: Height velocity percentile is NOT the same as height for age percentile.
- iv.** Without growth hormone therapy, the patient's predicted adult height is  $< 160$  cm (63 inches) in males or  $< 150$  cm (59 inches) in females; AND
- v.** Patient's epiphyses are open; AND
- vi.** Patient does not have constitutional delay of growth and puberty; AND
- vii.** The medication has been prescribed by or in consultation with an endocrinologist; OR

**B) Patient is currently Receiving Sogroya or is switching to Sogroya from another Growth Hormone Agent.** Approve for 1 year if the patient meets at least ONE of the following (i or ii):

- i.** Patient has received Sogroya or another Growth Hormone Agent for  $\geq 6$  months and  $< 10$  months. Approve if the patient meets BOTH of the following (a and b):
  - a)** Patient is  $\geq 5$  years of age; AND

**b)** Patient's annualized growth rate has doubled in comparison to the previous year; OR

Note: For example, if the growth velocity was 3 cm/year for the year prior to treatment, then the growth velocity must be at least 3 cm in 6 months (baseline velocity was 1.5 cm/6 months) or for example, the growth velocity was 2 cm/year for the year prior to treatment, then after 6 months of growth hormone therapy, the growth velocity must be at least 2 cm in 6 months (1 cm/6 months baseline).

**ii.** Patient has received Sogroya or another Growth Hormone Agent for  $\geq$  10 months. Approve if the patient meets at least ONE of the following (a, b, or c):

**a)** Patient is  $\geq$  5 years and  $<$  12 years of age. Patient's height has increased by  $\geq$  2 cm/year in the most recent year; OR

**b)** Patient is  $\geq$  12 years of age and  $<$  18 years of age. Patient meets BOTH of the following (1 and 2):

**(1)** Patient's height has increased by  $\geq$  2 cm/year in the most recent year; AND

**(2)** Patient's epiphyses are open; OR

**c)** Patient is  $\geq$  18 years of age. Patient meets ALL of the following (1, 2, and 3):

**(1)** Patient's height has increased by  $\geq$  2 cm/year in the most recent year; AND

**(2)** Patient's epiphyses are open; AND

**(3)** Patient's mid-parental height has not been attained.

Note: Mid-parental height is the father's height plus the mother's height divided by 2, plus 2.5 inches if male or minus 2.5 inches if female.

**4. Noonan Syndrome in a Child or Adolescent.** Approve for 1 year if the patient meets BOTH of the following (A and B):

**A)** The diagnosis of Noonan syndrome has been confirmed by ONE of the following (i or ii):

**i.** Noonan syndrome has been confirmed by a heterozygous pathogenic variant in BRAF, KRAS, MAP2K1, MRAS, NRAS, PTPN11, RAF1, RASA2, RIT1, RRAS2, SOS1 or SOS2 OR by either a heterozygous variant or biallelic pathogenic variants in LZTR1; OR

**ii.** If genetic testing does not definitively confirm the diagnosis, the prescriber has made a clinical diagnosis of Noonan syndrome: AND

Note: Clinical diagnosis includes abnormal facial features (high forehead, epicanthic folds, etc.), pulmonary valve stenosis and/or hypertrophic cardiomyopathy, first-degree relative with Noonan syndrome, mild developmental delay.

**B)** Patient meets at least ONE of the following (i or ii):

**i.** Initial therapy with any Growth Hormone Agent. Approve if the patient meets BOTH of the following (a and b):

**a)** Patient's baseline height is less than the 5<sup>th</sup> percentile using a growth chart for children without Noonan syndrome; AND

- b) The medication was prescribed by or in consultation with an endocrinologist; OR
- ii. Patient is Currently Receiving Sogroya or is switching to Sogroya from another Growth Hormone Agent (Patient has been established on either therapy for  $\geq 10$  months). Approve if the patient meets BOTH of the following (a and b):
  - a) Patient's height has increased by  $\geq 2$  cm/year in the most recent year; AND
  - b) Patient's epiphyses are open.

**5. Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russell Syndrome.** Approve for 1 year if the patient meets BOTH of the following (A and B):

- A) Patient meets BOTH of the following (i and ii):
  - i. Patient was born small for gestational age, which is defined as birth weight and/or birth length that is  $> 2$  standard deviations (SD) below the mean ( $< -2$  SD) for gestational age and gender; AND
  - ii. Patient did not have sufficient catch-up growth before age 2 to 4 years; AND
- B) Patient meets at least ONE of the following (i or ii):
  - i. Initial therapy with any Growth Hormone Agent. Approve if the patient meets ALL of the following (a, b, and c):
    - a) Patient is  $\geq 2$  years of age; AND
    - b) Patient's baseline height is less than the 5<sup>th</sup> percentile for age and gender; AND
    - c) The medication has been prescribed by or in consultation with an endocrinologist; OR
  - ii. Patient is Currently Receiving Sogroya or is switching to Sogroya from another Growth Hormone Agent (Patient has been established on either therapy for  $\geq 10$  months). Approve if the patient meets at least ONE of the following (a or b):
    - a) Patient is  $< 12$  years of age. Patient's height has increased by  $\geq 2$  cm/year in the most recent year; OR
    - b) Patient is  $\geq 12$  years. Patient meets BOTH of the following (1 and 2):
      - (1) Patient's height has increased by  $\geq 2$  cm/year in the most recent year; AND
      - (2) Patient's epiphyses are open.

**CONDITIONS NOT COVERED**

- **Sogroya® (somapacitan-beco subcutaneous injection - Novo Nordisk) is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):**

Note: For some of the following indications, authorization for coverage is not recommended because this indication is excluded from coverage in a typical pharmacy benefit.

- 1. Acute Critical Illness Due to Complications Following Surgery, Multiple Accidental Trauma, or with Acute Respiratory Failure.**<sup>1</sup> Sogroya is contraindicated in acute critical illness after open-heart surgery, abdominal surgery, multiple accidental trauma, or those with acute respiratory failure because of the risk of increased mortality.
- 2. Aging (i.e., Anti-Aging), to Improve Functional Status in an Elderly Patient, and Somatopause.**<sup>13,14,17,18</sup> Somatropin is not FDA-approved for anti-aging therapy, to improve functional status in elderly patients, or to treat somatopause. Federal law prohibits the distribution or dispensing of somatropin for non-FDA approved uses. There are no long-term studies assessing somatropin efficacy and safety for anti-aging therapy. Short-term therapy with somatropin may improve some measures of body composition, including increased muscle mass, reduced total body fat, improved skin elasticity, and reduced rate of bone demineralization, but somatotropin does not have positive effects on strength, functional capacity, or metabolism. Somatropin is associated with considerable adverse effects in non-growth hormone deficient adults (e.g., carpal tunnel syndrome, soft tissue edema, arthralgias, glucose intolerance, increased serum lipids). Another concern is the possible increased risk of cancer with long-term use of somatropin and the potentiating effects of insulin growth factor (IGFs) on cancer. Somatropin is not indicated for the age-related decrease in growth hormone/IGF-1 status.<sup>12</sup>
- 3. Athletic Ability Enhancement.**<sup>5</sup> Somatropin is not FDA-approved for athletic performance enhancement or for body building in nonathletes. Federal law prohibits the distribution or dispensing of somatropin for non-FDA approved uses. Short-term administration of somatropin to increase strength and endurance in athletes is no more effective than training alone and somatropin should not be administered to athletes or other persons for the purpose of enhancing athletic ability or improving personal appearance (i.e., to appear leaner and more muscular). Somatropin has been used in supraphysiologic doses alone or in combination with other performance enhancing drugs (PEDs) in users who are not athletes.<sup>34</sup> Use of PEDs has been linked to an increased risk of death and many adverse effects including cardiovascular, psychiatric, metabolic, endocrine, neurologic, infectious, hepatic, renal, and musculoskeletal disorders.
- 4. Central Precocious Puberty (CPP).** Children with precocious puberty are often treated with gonadotropin releasing hormone (GnRH) agonists (Lupron® [leuprolide acetate injection]) to suppress pituitary gonadal activity, to slow the advancement of bone age (prevent premature fusion of the epiphyseal growth plates), and to improve adult height. In some patients GnRH agonist therapy may result in marked deceleration of bone growth and may result in adult height that is less than the mid-parental height. Small and nonrandomized studies have demonstrated a significant improvement in final adult height over pre-treated

predicted adult height in patients treated with GnRH agonist and GH as compared with patients treated with GnRH agonist alone. However, larger randomized studies are lacking, and routine use of GH in this setting is not recommended.<sup>6,7</sup>

**5. Chronic Fatigue Syndrome.** There is no evidence of GHD in chronic fatigue syndrome.<sup>19</sup>

**6. Congenital Adrenal Hyperplasia (CAH).**<sup>8,9</sup> The Endocrine Society clinical practice guidelines on CAH due to steroid 21-hydroxylase deficiency recommend against the use of experimental treatment approaches outside of formally approved clinical trials.<sup>9</sup> Children with predicted adult height standard deviation  $\leq -2.25$  may be considered for growth-promoting treatments in appropriately controlled trials.

**7. Constitutional Delay of Growth and Puberty.** These children have delayed skeletal maturation and pubertal development. Administering somatropin does not increase adult height (which is usually normal).<sup>10</sup> Short-term androgen therapy accelerates growth and the rate of pubertal advancement in boys.

**8. Fibromyalgia.** In one placebo-controlled study, 120 non-GHD adult women with severe fibromyalgia and low levels of IGF-1 were randomized to somatropin 0.006 mg/kg/day for 12 months (dose was adjusted) or placebo for 6 months.<sup>20</sup> Patients receiving placebo initially were switched to somatropin from Months 6 to 12 (open label). Standard therapy for fibromyalgia was continued. After 6 months, there were no differences between somatropin and placebo in the percentage of patients with fewer than 11 positive tender points, mean number of tender points, intensity of pain in every point evaluated, and other measures. After 12 months of somatropin therapy, 53% of patients had less than 11 positive tender points compared with 33% of patients who received placebo and then somatropin for 6 months ( $P < 0.05$ ). At 18 months follow-up evaluation when somatropin was discontinued, impairment in pain perception worsened in both groups but to a lesser extent in the patients on somatropin for 12 months. Further controlled trials are needed with a longer duration,<sup>21</sup> with different doses, and using the 2010 American College of Rheumatology criteria for fibromyalgia. Some patients with fibromyalgia may have adult GHD.

**9. Infertility.** Some trials have demonstrated that GH intervention is associated with improved in-vitro fertilization (IVF) reproductive outcome, but others have concluded there is no evidence of an increased chance of a live birth with use of somatropin. More randomized controlled clinical trials with rigorous methodology are needed to confirm the beneficial effects of GH on assisted reproductive technology outcomes.<sup>23</sup> A 2025 phase III open-label study showed that empiric adjuvant GH therapy in GnRH antagonist cycles does not improve IVF stimulation results or reproductive outcomes, including implantation, miscarriage, and clinical pregnancy rates.<sup>22</sup>

**10. Obesity.**<sup>24,25</sup> Somatropin is not indicated for the treatment of obesity. Low growth hormone levels are a consequence of central obesity and not a cause.

Obesity is associated with decreased basal and pulsatile release of growth hormone and decreased stimulated growth hormone release. Somatropin therapy does not have significant beneficial effects on obesity in persons without GHD and does not produce significant overall weight loss. Supraphysiologic doses of somatropin have been used to treat obesity. Effects of long-term therapy with somatropin are unknown.

**11. Osteoporosis.**<sup>13,14</sup> Guidelines for treatment or prevention of osteoporosis do not include recommendations for use of somatropin. In one double-blind trial, 80 postmenopausal women with osteoporosis (56% of patients [n = 45/80] had a history of fractures) were randomized to somatropin 0.33 mg/day or 0.83 mg/day or to placebo for 3 years.<sup>13</sup> The double-blind phase was 18 months and patients on somatropin continued drug for another 18 months and patients on placebo stopped at 18 months. Patients were compared with an age-matched random population sample of women (n = 120). All patients received calcium 750 mg, vitamin D 400 units, and hormone replacement therapy. All women were followed for 10 years total. Bone mineral density increased in the patients receiving somatropin at Years 4 and 5, and after 10 years, had decreased to similar levels as before treatment. At 10 years, 28% of women (n = 22/80) had fractures. In the control group, fractures increased from 8% of patients at baseline to 32% of patients after 10 years. At 10 years, 41% of patients (n = 33/80) had stopped hormone replacement therapy; 23% had started bisphosphonates due to fractures, and 3% had received Forteo® (teriparatide injection). Larger studies are needed to determine the effects of somatropin therapy on bone mineral density and fractures in non-growth hormone deficient persons.

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## HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	05/31/2023
Selected Revision	<b>Growth Hormone Deficiency in a Child or Adolescent (≥ 2.5 years of age):</b> Criterion that specified the result of a growth hormone stimulation test to be < 10 ng/mL was added. Criterion that the stimulation test shows an inadequate response as defined by a peak response below the normal reference range as determined by the testing laboratory was removed.	11/01/2023
Annual Revision	No criteria changes.	06/12/2024
Annual Revision	<b>Growth Hormone Deficiency in a Child or Adolescent (≥ 2.5 years of age):</b> The wording "at least" was added to the requirement for two growth hormone stimulation tests < 10 ng/mL. Updated the wording "Patient has been evaluated by an endocrinologist" to "The medication has been prescribed by or in consultation with an endocrinologist." <b>Growth Hormone Deficiency in Adult or Transition Adolescent:</b> The criterion "Patient (adult onset or transition adolescent) has three or more of the following pituitary hormone deficiencies:" was updated to "Patient (adult onset or transition adolescent) has or had three or more of the following pituitary hormone deficiencies prior to hormone replacement therapy (if hormone therapy if required)." The criterion "The age and gender adjusted serum insulin-like growth factor-1 is below the lower limit of the normal reference range for the reporting laboratory" was updated to "The age and gender adjusted serum insulin-like growth factor-1 is or was below the lower limit of the normal reference range for the reporting laboratory (...), prior to growth hormone therapy". Also updated the wording "Patient has been evaluated by an endocrinologist" to "The medication has been prescribed by or in consultation with an endocrinologist."	06/18/2025
Selected Revision	The following statement in the Policy Statement was updated to include a clinician nurse: "All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria."	08/13/2025
Selected Revision	<b>Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent, Noonan Syndrome in a Child or Adolescent, Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russel Syndrome:</b> These conditions of approval were added to the policy.	04/08/2026

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