



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Skytrofa

Page: 1 of 4

Effective Date: 10/1/2023

Last Review Date: 8/24/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> New Jersey
	<input type="checkbox"/> Maryland	<input type="checkbox"/> Florida Kids	<input checked="" type="checkbox"/> Pennsylvania Kids
	<input type="checkbox"/> Michigan	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Skytrofa under the patient's prescription drug benefit.

Description:

FDA-Approved Indications

Skytrofa 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 growth hormone.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Skytrofa

Policy/Guideline:

I. FORMULARY PREFERENCING

- A. For pediatric members that are 2 years of age or older, the member was unable to take Norditropin and Humatrope, the preferred formulary alternatives, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review for both initial and continuation of therapy requests (where applicable):

- A. Medical records supporting the diagnosis of neonatal growth hormone deficiency
- B. Pretreatment growth hormone provocative test result (laboratory report or medical record documentation)
- C. Growth chart
- D. Pretreatment IGF-1 level (laboratory report or medical record documentation)
- E. The following information must be provided for all continuation of therapy requests:
 - 1. Total duration of treatment (approximate duration is acceptable)
 - 2. Date of last dose administered
 - 3. Approving health plan/pharmacy benefit manager



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4. Date of prior authorization/approval
5. Prior authorization approval letter

III. CRITERIA FOR INITIAL APPROVAL

Pediatric growth hormone (GH) deficiency

Authorization may be granted to members with pediatric GH deficiency 1 year of age and older when EITHER criteria A. or B. is met:

- A. Member was diagnosed with GH deficiency as a neonate. Medical records must be available to support the diagnosis of neonatal GH deficiency (e.g., hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiency, chart notes, or magnetic resonance imaging [MRI] results).
 - B. Member meets ALL of the following:
 1. Member has EITHER:
 - i. Two pretreatment pharmacologic provocative GH tests with both results demonstrating a peak GH level <10 ng/mL

OR

 - ii. A documented pituitary or CNS disorder (refer to Appendix A) and a pretreatment IGF-1 level >2 standard deviations below the mean
 2. For members <2.5 years of age at initiation of treatment, the pretreatment height is >2 SD below the mean and growth velocity is slow
 3. For members ≥ 2.5 years of age at initiation of treatment:
 - i. Pretreatment height is >2 SD below the mean and 1-year height velocity is >1 SD below the mean

OR

 - ii. Pretreatment 1-year height velocity is >2 SD below the mean
4. Epiphyses are open

IV. CRITERIA FOR CONTINUATION OF THERAPY

Pediatric GH deficiency

Authorization may be granted for continuation of therapy when ALL of the following criteria are met:

- A. Epiphyses are open (confirmed by X-ray or X-ray is not available)
- B. Member's growth rate is >2 cm/year unless there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty)



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V. APPENDIX

Examples of Hypothalamic/Pituitary/CNS Disorders

1. Congenital genetic abnormalities
 - a. Transcription factor defects (PIT-1, PROP-1, LHX3/4, HESX-1, PITX-2)
 - b. Growth hormone releasing hormone (GHRH) receptor gene defects
 - c. GH secretagogue receptor gene defects
 - d. GH gene defects
 - e. GH receptor/post receptor defects
2. Congenital structural abnormalities
 - a. Optic nerve hypoplasia/septo-optic dysplasia
 - b. Agenesis of corpus callosum
 - c. Empty sella syndrome
 - d. Ectopic posterior pituitary
 - e. Pituitary aplasia/hypoplasia
 - f. Pituitary stalk defect
 - g. Holoprosencephaly
 - h. Encephalocele
 - i. Hydrocephalus
 - j. Anencephaly or prosencephaly
 - k. Arachnoid cyst
 - l. Other mid-line facial defects (e.g., single central incisor, cleft lip/palate)
 - m. Vascular malformations
3. Acquired structural abnormalities (or causes of hypothalamic/pituitary damage)
 - a. CNS tumors/neoplasms (e.g., craniopharyngioma, glioma/astrocytoma, pituitary adenoma, germinoma)
 - b. Cysts (Rathke cleft cyst or arachnoid cleft cyst)
 - c. Surgery
 - d. Radiation
 - e. Chemotherapy
 - f. CNS infections
 - g. CNS infarction (e.g., Sheehan's syndrome)
 - h. Inflammatory processes (e.g., autoimmune hypophysitis)
 - i. Infiltrative processes (e.g., sarcoidosis, histiocytosis, hemochromatosis)
 - j. Head trauma/traumatic brain injury



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- k. Aneurysmal subarachnoid hemorrhage
- l. Perinatal or postnatal trauma
- m. Surgery of the pituitary or hypothalamus

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Skytrofa [package insert]. Palo Alto, CA: Ascendis Pharma, Inc.; August 2021.
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3. National Institute for Clinical Excellence: Guidance on the use of human growth hormone (somatropin) for the treatment of growth failure in children. May 2010. <http://www.nice.org.uk/nicemedia/live/12992/48715/48715.pdf>. Accessed January 10, 2022.
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