SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: select one drug below

❑ **Egrifta SV®**(tesamorelin)	❑ **Egrifta WR™** (tesamorelin)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limits:

- Egrifta SV Subcutaneous 2 mg single-patient-use vials: 30 vials per 30 days
  - NDC 62064-241-30
- Egrifta WR Subcutaneous 11.6mg single-patient-use vials: 4 vials per 28 days
  - NDC 62064-381-04

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

❑ Member is 18 years of age or older

(Continued on next page)

- ❑ Member has a diagnosis of Human Immunodeficiency Virus Infection with Lipodystrophy
- ❑ Medication is prescribed by or in consultation with an endocrinologist or a physician specializing in the treatment of HIV infection
- ❑ Member is currently receiving and adherent to antiretroviral therapy **(verified by pharmacy paid claims)**
- ❑ Prescribed therapy will **NOT** be used in combination with any form of growth hormone (somatropin) or IGF-1 (mecasermin)
- ❑ Provider will use tesamorelin to reduce excess abdominal visceral adipose tissue (VAT), and **NOT** for the following:
  - Abdominal obesity in a patient without Human Immunodeficiency Virus (HIV) infection
  - Human Immunodeficiency Virus (HIV)-Related cachexia, weight loss, or fat distribution other than Lipodystrophy
- ❑ Member meets **ONE** of the following clinical indicators for abdominal lipodystrophy **(submit documentation)**:
  - ❑ If female, waist circumference ≥ 94 cm and waist-hip ratio ≥ 0.88
  - ❑ If male, waist circumference ≥ 95 cm and waist-hip ratio ≥ 0.94
- ❑ Provider must submit documentation to confirm member has a body mass index (BMI) greater than 20 kg/m^2
- ❑ Member has no active malignancy (for example, a potential cancer which is being evaluated or a diagnosed cancer which is being treated)
- ❑ Member is **NOT** currently pregnant or breast-feeding

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Provider must submit documentation to confirm the member has exhibited a clear response in reduction of visceral adipose tissue measured by waist circumference or computed tomography (CT) scan
- ❑ Member does **NOT** demonstrate persistent elevated insulin-like growth factor 1 (IGF-1) levels (> 3 standard deviations above normal per the package insert)
- ❑ Member does **NOT** have unacceptable toxicity from the drug (e.g., severe injection site reactions, severe fluid retention, and severe hypersensitivity reactions)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 9/25/2025
REVISED/UPDATED/REFORMATTED: 10/15/2025