

Applicable Drugs: Egriftra SV (tesamorelin),
Egriftra WR (tesamorelin)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 1/13/2026

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through IV are met)

- I. Clinical and laboratory documentation of ALL the following (A through E):
 - A. Age: ≥ 18 years old.
 - B. Diagnosis of human immunodeficiency virus-associated lipodystrophy and criteria i or ii is met:
 - i. Male: Waist circumference ≥ 37.4 inches (95 cm) **AND** waist-to-hip ratio ≥ 0.94 .
 - ii. Female: Waist circumference ≥ 37 inches (94 cm) **AND** waist-to-hip ratio is ≥ 0.88 .
 - C. Documentation that excess accumulation of abdominal fat has impaired function, significantly limiting instrumental activities of daily living (IADL) (e.g., meal preparation, household chores). Intermittent occupational tasks that are not required as a daily part of job functioning are not considered IADL.
 - D. Patient has been stable on an antiretroviral regimen for at least 8 weeks.
 - E. Lateral (side view) photographs including the abdomen are required with the submitted clinical description.
- II. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical practice guidelines.
- III. Drug is prescribed by or in consultation with an endocrinologist or a physician specializing in the treatment of HIV infection (e.g. infectious disease specialist).
- IV. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- Disruption of the hypothalamic-pituitary axis
- Active malignancy
- Current pregnancy or breastfeeding
- Renal or hepatic impairment
- Acute critical illness

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Egrifra SV: thirty 2 mg single-dose vials per 30 days
- Egrifra WR: four 11.6 mg vials per 28 days

APPROVAL LENGTH

- **Authorization:** 6 months.
- **Re-Authorization:** 1 year, with an updated letter of medical necessity or progress notes confirming a reduction in waist circumference and improvement or resolution of functional impairment. The submission must also include at least one IGF-1 level obtained within the past six months, along with evidence that IGF-1 is not elevated (e.g., ≤ 3 standard deviation score).

APPENDIX

N/A

REFERENCES

1. Egrifra SV. Prescribing information. Theratechnologies Inc; February 2024. Accessed January 13, 2026. <https://www.theratech.com/static-files/2de95bab-bd94-4c00-84ca-321c9fe9f5b6>
2. Egrifra WR. Prescribing information. Theratechnologies Inc; March 2025. Accessed January 13, 2026. <https://www.theratech.com/static-files/f4fb8723-cb91-4b32-bc87-2f89bd8b52c0>
3. Falutz J, Potvin D, Mamputu JC, et al. Effects of tesamorelin, a growth hormone-releasing factor, in HIV-infected patients with abdominal fat accumulation: a randomized placebo-controlled trial with a safety extension. *J Acquir Immune Defic Syndr*. 2010;53(3):311-22. doi: 10.1097/QAI.0b013e3181cbdaff

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.