BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

EGRIFTA SV® (tesamorelin acetate) subcutaneous solution
EGRIFTA WR™ (tesamorelin acetate) subcutaneous solution
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Medical Necessity Requirements for EGRIFTA SV (tesamorelin acetate) and EGRIFTA WR (tesamorelin acetate)

Indication
- Egrifta SV (tesamorelin acetate) or Egrifta WR (tesamorelin acetate) for treatment of excess abdominal fat in patients with lipodystrophy is considered ***not medically necessary*** based upon insufficient evidence to support improvement of the net health outcome.

ORIGINAL EFFECTIVE DATE: 02/21/2019 | ARCHIVE DATE: | LAST REVIEW DATE: 11/19/2026 | LAST CRITERIA REVISION DATE: 11/20/2025

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EGRIFTA WR™ (tesamorelin acetate) subcutaneous solution
Generic Equivalent (if available)

Description:

Egrifta SV (tesamorelin acetate) or Egrifta WR (tesamorelin acetate) is a growth hormone releasing factor (GHRF) analog that is indicated for the reduction of excess abdominal fat in HIV-infected adult individuals with lipodystrophy. It is **not** indicated for weight loss management. There is no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking tesamorelin. In addition, the long-term cardiovascular safety of tesamorelin has not been established.

Resources:

Egrifta SV (tesamorelin) injection product information, revised by Theratechnologies, Inc. 02-2024. Available at DailyMed http://dailymed.nlm.nih.gov. August 14, 2026.

Egrifta WR (tesamorelin) injection product information, revised by Theratechnologies, Inc. 03-2025. Available at DailyMed http://dailymed.nlm.nih.gov. August 14, 2026.

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