AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Egrifta	Page:	1 of 2
Effective Date:	4/21/2025	Last Review Date:	4/2025

Applies to:	☒Illinois	☐Florida	☒Florida Kids
	☐New Jersey	☒Maryland	☒Michigan
	☒Pennsylvania Kids	☒Virginia	☐Arizona

Intent:

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

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Egrifta SV is indicated for the reduction of excess abdominal fat in human immunodeficiency virus (HIV)-infected adult patients with lipodystrophy.

Limitations of Use:
A. Long-term cardiovascular safety of Egrifta SV has not been established.
B. Egrifta SV is not indicated for weight loss management as it has a weight neutral effect.
C. There are no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking Egrifta SV.

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

Applicable Drug List:

Non-Preferred: Egrifta

Policy/Guideline:

Prescriber Specialty:
This medication must be prescribed by or in consultation with an infectious disease specialist.

Criteria for Initial Approval:
Authorization of 6 months may be granted for reduction of excess abdominal fat in HIV-infected patients with lipodystrophy when the patient is currently receiving anti-retroviral therapy.

Continuation of Therapy:

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for reduction of excess abdominal fat when all of the following criteria are met:

A. The member has HIV infection and lipodystrophy
B. The member is currently receiving anti-retroviral therapy
C. The member has demonstrated a clear clinical improvement from baseline that is supported by waist circumference measurement or computed tomography (CT) scan

Note: Coverage will not be provided for weight loss.

Approval Duration and Quantity Restrictions:

Approval:
Initial Approval: 6 months
Renewal Approval: 6 months

Quantity Level Limit: 30 vials per 30 days
Reference Formulary for drug specific quanitity level limits

References:

1. Egrifta SV [package insert]. Montreal, Québec, Canada: Theratechnologies Inc.; February 2024.
2. Brown TT. Approach to the human immunodeficiency virus-infected patient with lipodystrophy. J Clin Endocrinol Metab. 2008;93(8):2937-2945.