



Growth Hormone

Therapeutic Class Review (TCR)

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FDA-APPROVED INDICATIONS

Drug	Manufacturer	FDA-Approved Indications				
		GHD (Pediatric/ Adult)	Turner Syndrome	CRI	ISS	Other
Genotropin ^{®1}	Pfizer	X	X		X	PWS, SGA
Humatrope ^{®2}	Lilly	X	X		X	SHOX, SGA
Norditropin ^{®3}	Novo Nordisk	X	X			Noonan Syndrome, SGA
Nutropin AQ ^{®4}	Genentech	X	X	X	X	
Omnitrope ^{®5}	Sandoz	X	X		X	PWS, SGA
Saizen ^{®6}	EMD Serono	X				
Serostim ^{®7}	EMD Serono					HIV wasting or cachexia to increase lean body mass and weight, and improve physical endurance
Tev-Tropin ^{®8}	Gate/Teva	X (pediatric only)				
Zorbtive ^{®9}	EMD Serono					SBS

GHD = Growth hormone deficiency

PWS = Prader-Willi Syndrome

CRI = Chronic renal insufficiency

SGA = Small for gestational age

ISS = Idiopathic short stature

SHOX = Short stature homeobox gene

SBS = Short bowel syndrome

HIV = Human Immunodeficiency Virus

OVERVIEW

Human growth hormone (hGH, somatotropin) is a 191-amino acid polypeptide hormone secreted by the anterior pituitary gland. It has important metabolic effects including stimulation of protein synthesis and cellular uptake of amino acids. Previously, the only source of exogenous growth hormone was human cadavers. Advances in biotechnology, however, have made recombinant DNA-derived growth hormone available for general use. Exogenous growth hormone is used to treat a variety of disorders in which endogenous growth hormone is insufficient to meet the needs of the patient. The 2009 American Association of Clinical Endocrinologists Guidelines for Clinical Practice indicates that no evidence exists to support any specific growth hormone product over another.¹⁰

Growth hormone deficiency (GHD) results from inadequate production of growth hormone (GH) and can produce various medical conditions dependent on age. In infancy and childhood, growth failure may be the major effect. Adults with GHD may have diminished lean body mass, poor bone density, and a number of physical and psychological manifestations. GHD can be congenital or acquired in childhood or adult life, in addition to being partial or complete. The condition is usually permanent and may be an isolated deficiency or occur in association with deficiencies of other pituitary hormones.

Prader-Willi Syndrome (PWS) is a genetic disorder in which seven genes on chromosome 15 are missing or unexpressed on the paternal chromosome.¹¹ PWS is characterized by hyperphagia and food preoccupations, as well as small stature and mental retardation. The major manifestations of PWS are neurobehavioral and endocrine abnormalities, hypothalamic obesity, hypotonia, short stature, developmental delay, and aspects of hypothalamic endocrine dysfunction and pubertal delay or

absence. In some cases, the impaired GH secretion (which can persist into adulthood) may be the result of hypothalamic dysfunction. Daily growth hormone injections support linear growth and increased muscle mass, and may lessen food preoccupation and weight gain in patients with PWS.

Children with chronic renal insufficiency (CRI) may have difficulty attaining a normal height and weight for several reasons, including malnutrition, renal osteodystrophy, electrolyte, calcium and vitamin D imbalances, inadequate use of protein by the body, and abnormalities in the growth hormone (GH)-insulin-like growth factor (IGF)-I axis. In CRI, GH levels may be normal or elevated, however patients may exhibit insensitivity to the action of GH. In addition, levels of free IGF-1 may be reduced, thereby decreasing its bioavailability. These GH/IGF-1 axis disturbances can be overcome by the administration of supraphysiological doses of exogenous GH.^{12, 13}

Babies born small for gestational age (SGA) are those with birth weights that fall below the tenth percentile for that gestational age. Typically, intrauterine growth retardation is the causative factor. Although the majority of these children catch up in height to normal range during the first two years of life, approximately ten percent of SGA children fail to exhibit catch-up growth by age two years. Growth hormone levels in these children may be low or within normal range. Decreased growth may be due to insensitivity to growth hormone as well as low IGF-1 levels. It is thought that administering exogenous GH may overcome GH insensitivity. If left untreated, these children are likely to remain below expected height throughout adolescence and adulthood.^{14, 15}

Short stature homeobox gene (SHOX) is a gene on the X and Y chromosomes that control the formation of many body structures, including the growth and maturation of bones in the arms and legs. Patients with SHOX deficiency (gene mutation or present in only one copy) may present with a broad phenotypic spectrum ranging from isolated short stature with no distinguishing clinical features to short stature with moderate to severe skeletal dysplasia. Approximately two to three percent of patients with clinical features consistent with idiopathic short stature may test positive for SHOX deficiency.¹⁶

In Turner syndrome (TS), female sexual characteristics are present but are underdeveloped due to several chromosomal abnormalities. Short stature affects at least 95 percent of all patients with TS. The etiology of the growth retardation may be due to haploinsufficiency of the SHOX gene, not GHD. However, subnormal levels of GH and IGF-I have been reported, and it has been postulated that a diminished sensitivity for growth factors might explain the short stature.¹⁷ Short stature in patients with TS is characterized by mild intrauterine growth retardation, slow growth during infancy, delayed onset of the childhood component of growth, and growth failure during childhood and adolescence. These factors lead to a diminished final height which can be positively affected by growth hormone therapy.

Idiopathic short stature (ISS) is defined by the Growth Hormone Research Society as a condition in which the height of an individual is more than a 2.0 standard deviation score (SDS) below the corresponding mean height for a given age, sex, and population group without evidence of systemic, endocrine, nutritional, or chromosomal abnormalities.¹⁸ Specifically, children with ISS have normal birth weight and are GH sufficient.

Patients with HIV/AIDS may experience cachexia: loss of weight, muscle atrophy, fatigue, weakness, and anorexia. Serostim is indicated for the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight and improve physical endurance. Human growth hormone therapy allows the body to use fat for energy, thereby preserving lean body mass.¹⁹

Short bowel syndrome (SBS) is a malabsorption disorder caused by either the surgical removal of the small intestine or the loss of its absorptive function due to various diseases. Intestinal mucosa contains receptors for growth hormone and for Insulin-like Growth Factor 1 (IGF-1), which is known to mediate many of the cellular actions of growth hormone. In human clinical studies, the administration of growth hormone enhanced the transmucosal transport of water, electrolytes, and nutrients. Zorbtive is indicated for the treatment of Short Bowel Syndrome (SBS) in patients receiving specialized nutritional support.²⁰

The principal features of Noonan Syndrome, a congenital disorder, include heart malformation, short stature, indentation of the chest, learning disabilities, impaired blood clotting, and a certain configuration of facial features. Short stature is present in as many as 80 percent of patients. Growth hormone has been used successfully to correct short stature associated with the disorder.²¹

PHARMACOLOGY

Somatropin is a polypeptide hormone of recombinant DNA origin. The amino acid sequence of somatropin is identical to that of hGH of pituitary origin.²² Growth-promoting effects of growth hormone are due to anabolic peptide formation mediated by insulin-like growth factors. The peptides, specifically IGF-1, act as direct stimulators of cell proliferation and growth. Skeletal and organ growth, the number and size of muscle cells, red blood cell mass, chondroitin and collagen synthesis, lipid mobilization, connective tissue, and the metabolism of minerals, proteins, carbohydrates, and lipids are all positively impacted by growth hormone. Somatropin also decreases fat mass and promotes increased lean body mass.

PHARMACOKINETICS^{23, 24, 25, , 26, 27, 28, 29, 30, 31}

Growth hormone is administered by IM or SC injection. The absolute bioavailability after a SC injection of somatropin ranges between 61 to 100 percent. Peak plasma concentrations of somatropin are reached three to seven hours following administration. Approximately 10 to 30 percent of the circulating somatropin is bound to growth hormone-binding protein. Peak plasma concentrations of IGF-1 occur about 20 hours after administration of somatropin. The plasma elimination half-life is approximately 20 to 30 minutes. Because of continued release of somatropin from the injection site, serum concentrations decline with a half-life of about two to ten hours. Because of the slow induction and clearance of IGF-1, the effects of somatropin last much longer than its elimination half-life. Somatropin is metabolized by the liver, kidney, and other tissues; little excretion occurs via the urine.

CONTRAINDICATIONS/WARNINGS^{32, 33, 34,35, 36, 37, 38, 39, 40}

Growth hormone is contraindicated in patients with the following conditions: closed epiphyses (pediatric patients only); active malignancy; acute critical illness in response to open heart surgery, abdominal surgery, multiple accidental trauma, or acute respiratory failure; Prader-Willi Syndrome who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment; and active proliferative or severe non-proliferative diabetic retinopathy. Patients with a known hypersensitivity to the drug or diluent should not use the product. Genotropin 5 mg and 12 mg and Tev-Tropin 10 mg contain the preservative m-cresol and should not be used in patients with a known hypersensitivity.

Treatment with growth hormone may decrease insulin sensitivity, especially at higher doses in susceptible patients. Growth hormone therapy has been associated with cases of new-onset impaired glucose intolerance, impaired fasting glucose, new-onset type 2 diabetes mellitus, and exacerbation of preexisting diabetes mellitus. All patients, especially patients with type 1 or 2 diabetes, impaired glucose tolerance, and those at high risk for developing diabetes mellitus should be monitored closely for hyperglycemia during growth hormone therapy. Alterations in antidiabetic medication therapy may be needed for some patients as a result.

Undiagnosed or untreated hypothyroidism may prevent an optimal response to growth hormone therapy, particularly in children, and monitoring is warranted. Patients with hypothyroidism or hypopituitarism should have their hormonal replacement therapy monitored when taking somatropin therapy.

Intracranial hypertension with visual changes, headache, nausea, vomiting, and papilledema has been reported in a small number of patients treated with growth hormone. Symptoms usually occurred within the first eight weeks after the initiation of therapy and resolved after stopping growth hormone therapy or reducing the dose. Prior to beginning growth hormone therapy a screening for pre-existing papilledema should be performed and routine checks thereafter are warranted. If papilledema occurs the somatropin therapy should be stopped and, if intracranial hypertension is diagnosed, therapy can be restarted after the signs and symptoms have resolved at a lower dose.

Fluid retention during somatropin replacement therapy in adults may frequently occur. Clinical signs of fluid retention are usually transient and dose dependent. Fluid retention can be manifested by edema, arthralgia, myalgia, and nerve compression syndromes, such as carpal tunnel syndrome and paraesthesias.

Patients with growth hormone deficiency secondary to intracranial lesions or preexisting tumors should be routinely monitored for progression or reoccurrence of the underlying disease. There has also been an increased risk of second neoplasms in childhood cancer survivors who are being treated with somatropin especially meningiomas. Patients should also be monitored for malignant skin lesions.

Slipped capital femoral epiphyses may occur more often in patients with endocrine disorders or in patients undergoing quick growth. Children should be monitored for onset of a limp or complaints of hip or knee pain during growth hormone therapy.

Progression of scoliosis can occur in patients who experience rapid growth but somatropin is not associated with increasing the incidence of scoliosis. Patients should be monitored for progression of the disease.

Bone age should be monitored during somatropin therapy in pubertal patients and/or patients receiving concomitant thyroid hormone therapy as epiphyseal maturation may progress quickly.

Carpal tunnel syndrome may occur during treatment with Serostim or Zorbtive. If the symptoms of carpal tunnel syndrome do not resolve with decreased dosing, growth hormone therapy should be discontinued.

Cases of pancreatitis have been reported rarely in children and adults receiving somatropin treatment. However, some evidence supports a greater risk of developing pancreatitis in children compared with adults. Published literature indicates that girls who have Turner syndrome may be at greater risk than

other children treated with somatropin. Pancreatitis should be considered in any somatropin-treated patient who develops abdominal pain especially when the patient is a child.

Patients with Turner Syndrome should be closely monitored for otitis media, other ear disorders, and cardiovascular complications since they are at an increased risk of an adverse event.

Fatalities have been reported with the use of growth hormone for pediatric patients with PWS having one or more of the following risk factors: severe obesity, history of respiratory impairment or sleep apnea, severe respiratory impairment, or an unidentified respiratory infection. Patients with PWS should be examined for upper airway obstruction and sleep apnea before starting somatropin therapy and routine monitoring should occur thereafter. If signs and symptoms of upper airway obstruction or sleep apnea occur somatropin therapy should be interrupted or discontinued. All PWS patients treated with somatropin should have their weight controlled and be monitored for signs and symptoms of respiratory infection and be treated aggressively if one occurs. Male patients with one of more of the aforementioned risk factors may be at greater risk of complications than females. Somatropin is contraindicated in these patients.

Caution should be advised when using growth hormone products as they may contain benzyl alcohol which has been associated with serious adverse events and death in pediatric patients. Practitioners administering these with other medications containing benzyl alcohol should consider the combined daily load of benzyl alcohol. When products are used in newborns, if appropriate, the medication should be reconstituted with sterile normal saline for injection; only one dose per vial should be used and the unused portion should be discarded.

Patients take somatropin therapy over a long period of time and should rotate injection sites to minimize local adverse reactions such as tissue atrophy. Local or systemic allergic reactions may occur at the somatropin injection sites.

Children using somatropin for the treatment of growth failure secondary to chronic kidney disease should be monitored for renal osteodystrophy.

In some in vitro experimental systems, somatropin has been shown to potentiate HIV replication. However, when antiretroviral agents (didanosine, lamivudine, zidovudine) were added there was no increase in viral production. In controlled clinical trials, no significant increases in viral burden occurred which was associated with somatropin. Due to the potential increase of virus replication it is recommended that HIV patients remain on antiretroviral medications throughout Serostim therapy.

An increased risk of a second neoplasm has been reported in childhood cancer survivors who were treated with radiation to the brain/head for their first neoplasm who also developed subsequent growth hormone deficiency and were treated with somatropin. The most common intracranial tumors that develop in these patients are meningiomas. Patients should be monitored who have a history of growth hormone deficiency secondary to an intracranial neoplasm for progression or reappearance of tumors. Children with rare genetic causes of short stature have an increased risk of developing neoplasms; therefore, prescribers should consider the risk to benefit when starting somatropin therapy and monitor patients closely. Since HIV patients are more susceptible to malignancies prescribers should consider the benefits and risks of somatropin therapy.

In 2010 and 2011, the FDA reviewed the results of the French Sante Adulte GH Enfant Study (SAGhE). The study found persons with idiopathic growth hormone deficiency and idiopathic or gestational short stature, who were treated with long-term recombinant human growth hormone during childhood,

were at a small increased risk for death compared to individuals in the general French population.^{41, 42} In the study, there was a 30 percent increased risk for death in patients using recombinant human growth hormone therapy compared with the general French population. The risk of death was increased when doses of recombinant growth hormone that are higher than what is normally prescribed for pediatric growth hormone deficiency were used. In 2011, the FDA determined the evidence from the study was inconclusive due to the study having design weaknesses which limited the interpretability of the study and the study's data sources lacked evidence to support a link between recombinant human growth hormone and an increased risk of death. The FDA has recommended that prescribers and patients continue to prescribe and use recombinant human growth hormone according to the labeled recommendations. The FDA expects to have additional data from the study in 2012; however, to date, no updates have been published by the FDA.

DRUG INTERACTIONS^{43, 44, 45,46, 47, 48, 49, 50, 51}

Previously undiagnosed central hypoadrenalism may be discovered as a result of growth hormone therapy and glucocorticoid replacement may be needed. In patients already diagnosed with this condition, an increase in maintenance or stress dosing of glucocorticoids may be necessary. However, excessive glucocorticoid therapy will inhibit the growth-promoting effect of growth hormone.

Growth hormone treatment may alter the clearance of compounds known to be metabolized by the CYP450 liver enzymes (e.g., corticosteroids, sex steroids, anticonvulsants, and cyclosporine).

Women using oral estrogen replacement may require larger growth hormone doses to achieve treatment goals.

Patients who require treatment for diabetes should be monitored closely and adjustments to medications may be warranted.

ADVERSE EFFECTS^{52, 53, 54,55, 56, 57, 58, 59, 60}

Leukemia has been reported in a small number of GHD patients treated with growth hormone. It is not known if this increased risk is related to the pathology of GHD itself, growth hormone therapy, or other associated treatments, such as radiation therapy for intracranial tumors. However, current evidence does not support the conclusion that growth hormone therapy is the causative agent for this potential secondary malignancy. New onsets and reoccurrence of benign and cancerous neoplasms have also been reported.

Metabolic complications may be seen occasionally during growth hormone therapy; hyperglycemia, hypoglycemia, hypothyroidism, hypertriglyceridemia, glycosuria, and fluid retention have been reported. Peripheral edema may occur, more commonly in adults than children. In adults with GHD, edema or peripheral edema was reported in 42 percent of patients treated with growth hormone as compared to eight percent of placebo-treated patients.⁶¹ Edema usually occurs early in therapy and is transient or responsive to dosage reduction. During post-marketing surveillance, cases of new onset glucose intolerance, diabetes mellitus, and exacerbation of pre-existing diabetes mellitus have been reported. Some patients developed diabetic ketoacidosis and diabetic coma. In some patients, the conditions improved when growth hormone was discontinued while in others the glucose intolerance persisted. Some patients may require initiation or adjustment of antidiabetic treatment.

Pancreatitis, gastroenteritis, abdominal pain, nausea, and incidences of hyperlipidemia have also been reported in pediatric and adult patients.

Central nervous symptoms are common when using somatropin and include sensory changes, fatigue, weakness, headache, pain, arthralgia, paraesthesia, hypoesthesia, myalgia, skeletal pain, altered mood, and pain and stiffness of the extremities. These adverse events have been more commonly associated with adults than children. In adults treated with growth hormone, the onset of muscle and joint pain most often occurs early in therapy. As with edema, the pain tends to be transient or responds to a reduction in growth hormone dose.

Seizures and new onset, progression, and exacerbation of pre-existing scoliosis have been reported infrequently with growth hormone therapy.

In patients treated with growth hormone for Turner Syndrome, there is a statistically increased incidence of otitis media (43 percent), other ear disorders (18 percent), and surgical procedures (45 percent) as compared to placebo ($p \leq 0.05$). Other adverse reactions reported in patients with Turner syndrome included respiratory illness, joint pain, and urinary tract infections.

In patients treated with growth hormone for Prader-Willi syndrome, there were reports of edema, arthralgia, aggressiveness, benign intracranial hypertension, hair loss, myalgia, and headache.

Respiratory conditions such as upper respiratory infection, cough, respiratory disorder, pharyngitis, bronchitis, laryngitis, tonsillitis, nasopharyngitis, and rhinitis have been reported primarily in pediatric patients.

Infrequent reports of injection site reactions (e.g. pain or burning associated with the injection, fibrosis, rash, nodules, pigmentation, inflammation, or bleeding), headache, lipoatrophy, hematuria, mild hyperglycemia, and hypothyroidism have been reported. Compared to other somatropin products, injection site discomfort has been reported more frequently with the use of Nutropin AQ in pediatric patients.⁶²

Flu-like symptoms have been reported in adults and children.

Other adverse events, such as hypertension, hematoma, carpal tunnel syndrome, chest pain, depression, antibody formation, gynecomastia (in pediatrics), and insomnia have also been reported.

SPECIAL POPULATIONS^{63, 64, 65, 66, 67, 68, 69, 70, 71}

Pregnancy

Humatrope, Nutropin AQ, Norditropin, and Tev-Tropin are Pregnancy Category C. Genotropin, Omnitrope, Saizen, Serostim, and Zorbtive are Pregnancy Category B.

Hepatic Function Impairment

A reduction in recombinant human growth hormone (rhGH) clearance has been noted in patients with severe liver dysfunction. The clinical significance of this decrease is unknown.

Renal Function Impairment

Patients with chronic renal failure may experience decreased somatropin clearance compared to patients with normal renal function.

Other

There are no data at this time to suggest differences in pharmacokinetics or pharmacodynamics in other subsets of the population.

DOSAGES

SD = single-dose vial, MD = multiple-dose vial, IM = intramuscular, SC = subcutaneous

Drug (mfr)	Dosage Forms	Dosage
Genotropin ⁷² (Pfizer)	Two chamber cartridge (for use with Pen or Mixer): 5, 12 mg contains preservative MiniQuick® syringe device: 0.2-2 mg in 0.2 mg increments (SD) contains no preservative	Weekly doses should be divided into six or seven SC injections given in the thigh, buttocks, or abdomen and must not be injected intravenously. <ul style="list-style-type: none"> GHD (ped): 0.16 to 0.24 mg/kg/week divided and given as six or seven SC injections GHD (adult): no more than 0.04 mg/kg/week to start given as a daily SC injection; the dose may be increased at four- to eight-week intervals according to individual patient requirements and tolerance to a maximum of 0.08 mg/kg/week. The weekly dose should be divided and given as six or seven SC injections ISS: up to 0.47 mg/kg/week divided and given as six or seven SC injections PWS: 0.24 mg/kg/week divided and given as six or seven SC injections SGA: up to 0.48 mg/kg/week divided and given as six or seven SC injections TS: 0.33 mg/kg/week divided and given as six or seven SC injections
Humatrope ⁷³ (Lilly)	Vials (with diluent): 5 mg (MD) Cartridge kits (with prefilled diluent syringes): 6, 12, 24 mg (MD)	<ul style="list-style-type: none"> GHD (ped): 0.18 mg/kg/week up to 0.3 mg/kg/week divided and given SC six to seven times per week GHD (adult): not more than 0.006 mg/kg/day SC to start; may be increased to maximum of 0.0125 mg/kg/day ISS: up to 0.37 mg/kg/wk SC divided into equal doses and given six or seven times per week SGA: up to 0.47 mg/kg/week and given six to seven times per week SHOX: 0.35 mg/kg/week SC divided and given six to seven times per week TS: up to 0.375 mg/kg/week SC divided and given six to seven times per week
Norditropin ⁷⁴ (Novo Nordisk)	Nordiflex® prefilled pens: 30 mg (MD) FlexPro® prefilled pens: 5, 10, 15 mg (MD)	<ul style="list-style-type: none"> GHD (ped): 0.024 - 0.034 mg/kg/day given SC six or seven times per week GHD (adult): not more than 0.004 mg/kg/day SC to start; may increase to maximum of 0.016 mg/kg/day after six weeks Noonan Syndrome: up to 0.066 mg/kg/day SC TS: up to 0.067 mg/kg/day SC SGA: up to 0.067 mg/kg/day SC
Nutropin AQ Pen ⁷⁵ (Genentech)*	Pen cartridge: 20 mg (MD)	<ul style="list-style-type: none"> GHD (ped): prepubertal: up to 0.3 mg/kg/wk divided into daily SC injections GHD (ped): pubertal: up to 0.7 mg/kg/wk divided into daily SC injections GHD (adult): not more than 0.006 mg/kg/day SC to start; may increase according to patient requirements to maximum of 0.025 mg/kg/day in patients 35 years and younger and 0.0125 mg/kg daily in patients over 35 years. CRI: up to 0.35 mg/kg/week divided into daily SC injections ISS: up to 0.3 mg/kg/week SC divided into daily doses TS: up to 0.375 mg/kg/week SC divided into equal doses given three to seven times per week
Nutropin AQ ⁷⁶ NuSpin® (Genentech) ⁷⁷	Prefilled cartridge: 5, 10, 20 mg (MD)	

Dosages (continued)

Drug (mfr)	Dosage Forms	Dosage
Omnitrope ⁷⁸ (Sandoz)	Vials: 5.8 mg (MD) Cartridge: 5 mg/1.5 mL, 10 mg/1.5 mL (MD)	<ul style="list-style-type: none"> ▪ GHD (ped): 0.16 to 0.24 mg/kg SC per week divided into six to seven doses daily ▪ GHD (adult): not more than 0.04 mg/kg/week divided into daily SC injections, dosage may be increased at four to eight week intervals and should not exceed 0.08 mg/kg/week depending on patient's tolerance ▪ ISS: up to 0.47 mg/kg/week divided and given as six or seven daily SC injections ▪ PWS: 0.24 mg/kg/week divided and given as six or seven daily SC injections ▪ SGA: up to 0.48 mg/kg/week divided and given as six or seven daily SC injections ▪ TS: 0.33 mg/kg/week divided and given as six or seven daily SC injections
Saizen ⁷⁹ (Serono)	Vials (with diluent): 5, 8.8 mg (MD) Click.easy® cartridge: 8.8 mg (MD)	<ul style="list-style-type: none"> ▪ GHD (ped): 0.18 mg/kg/week divided into equal doses given either on three alternate days, six times per week or daily ▪ GHD (adult): not more than 0.005 mg/kg/day SC to start, dosage not to exceed 0.01 mg/kg/day after four weeks depending on patient's tolerance
Serostim ⁸⁰ (Serono)	Vials (with diluent): 5, 6 mg (SD) Vials (with diluent): 4 mg (MD)	<ul style="list-style-type: none"> ▪ HIV/AIDS wasting or cachexia: 0.1 mg/kg SC daily at bedtime (up to a total dose of 6 mg) or 0.1 mg/kg every other day
Tev-Tropin ⁸¹ (Gate/Teva)	Vials (with diluent): 5 mg (MD)	<ul style="list-style-type: none"> ▪ GHD (ped): up to 0.1 mg/kg SC three times per week
Zorbtive ⁸² (Serono)	Vials (with diluent): 8.8 mg (MD)	<ul style="list-style-type: none"> ▪ SBS: 0.1 mg/kg/day SC, maximum of 8 mg daily. Administration for greater than four weeks has not been adequately studied. Zorbtive is not indicated for patients less than 18 years of age or in adults older than 65 years of age.

*Genentech has discontinued Nutropin AQ 10 mg pens. Genentech is discontinuing Nutropin AQ 20 mg pens as well as Nutropin AQ cartridges (10 and 20 mg); product will remain available, until supply is exhausted.

DOSING CONSIDERATIONS^{83, 84, 85, 86, 87, 88}

Adults for GHD

Alternatively, taking into account further literature, a starting dose of approximately 0.2 mg/day (range, 0.15–0.30 mg/day) may be used without considering the patient's body weight. This dose can be increased gradually every one to two months by increments of approximately 0.1–0.2 mg/day, according to individual patient requirements based on serum IGF-I concentrations and clinical response. During therapy, the dose should be decreased, if required, by the occurrence of adverse events and/or serum IGF-I levels above the age- and gender-specific normal range. Maintenance dosages vary considerably between patients.

Since older patients are more likely to experience adverse effects of somatropin compared to younger individuals, a lower starting dose and smaller dose increments should be considered. In addition, obese individuals are more likely to experience adverse effects when treated with a weight-based regimen. Estrogen-replete women may need higher doses than men in order to reach the defined treatment goals and administration of oral estrogen may increase the dose requirements in women.

Pediatrics

Response to somatropin therapy in pediatric patients tends to decrease over time. The need for close assessment of compliance and evaluation for other causes of growth failure, such as hypothyroidism, undernutrition, advanced bone age, and antibodies to recombinant human GH (rhGH) may be needed in pediatric patients who have growth failure especially during the first year of therapy.

Treatment for short stature should be discontinued when the epiphyses are fused. Treatment with somatropin for growth failure due to GHD should be discontinued when epiphyses are fused.

Patients with SGA - According to the prescribing information for Humatrope and Norditropin: literature has recommended initial treatment with larger doses of somatropin (e.g., 0.067 mg/kg/day), especially in very short children (e.g., HSDS < -3), and/or older/early pubertal children, and that a reduction in dosage (e.g., gradually towards 0.033 mg/kg/day) should be considered if substantial catch-up growth is observed during the first few years of therapy. However, in younger SGA children (e.g., approximately less than four years), who respond the best in general, with less severe short stature (e.g., baseline HSDS values between -2 and -3), consideration should be given to initiating treatment at a lower dose (e.g., 0.033 mg/kg/day), and titrating the dose as needed over time. In all children, clinicians should closely monitor growth response, and adjust the rhGH dose as needed.

Formulation

Differences in the products with respect to dosages and some adverse effects are a reflection of the various dosage forms and product packaging. These differences should be considered when evaluating the products:

Vials

All products requiring reconstitution are supplied in kits containing a vial of active drug along with a vial of diluent. Reconstitution is a major cause of patient dissatisfaction. Solutions are also associated with greater convenience and reduced levels of pain associated with injection.⁸⁹ Solutions are easier for the majority of patients to use as no reconstitution is required.

Humatrope should be reconstituted with its diluent and swirled to mix. If sensitivity of the diluent occurs the medication may be reconstituted with bacteriostatic water for injection or sterile water for injection. Humatrope vials should be refrigerated and used within 14 days after reconstitution with bacteriostatic water or diluent. If reconstituted with sterile water, refrigerate and discard within 24 hours.

After reconstitution, the contents of Omnitrope vials must be refrigerated and used within three weeks.

Before reconstitution, Saizen vials should be stored at room temperature. Once reconstituted, the medication should be stored under refrigeration for up to 14 days.

Serostim vials and diluent should be stored at room temperature prior to first use. For single-use vials, the reconstituted solution should be used immediately and any unused portion should be discarded; reconstituted solution in the multi-use vials should be stored under refrigeration for up to 14 days.

Tev-Tropin requires refrigeration before and after reconstituting. Once reconstituted, the 5 mg product is stable for up to 14 days when reconstituted with bacteriostatic sodium chloride. The 10 mg product is stable for up to 28 days when reconstituted with one ml of bacteriostatic water for injection containing metacresol (preservative).

Zorbtive is available in vials; each vial (8.8 mg) is reconstituted in one to two mL of bacteriostatic water producing a concentration of 8.8 mg or 4.4 mg, respectively. Before reconstitution, the medication can be stored at room temperature. The reconstituted 8.8 mg may be refrigerated for up to 14 days.

Devices

Several of the products have specific devices to facilitate use of the medication by the patient or caregiver.

Genotropin is supplied in single-use syringe devices (MiniQuick, Pen) that allow for internal reconstitution. The MiniQuick is a single-use, disposable syringe that already houses a cartridge for internal reconstitution. The MiniQuick can be stored in the refrigerator or at room temperature (at or below 77°F) for up to three months; however, after reconstitution it can only be refrigerated for 24 hours. Cartridges are added to the Pen and Mixer devices. Both use internal reconstitution; the cartridges can be refrigerated before and after reconstitution for 28 days and can be reused. Somatropin cartridges must be used with their corresponding color-coded delivery systems.

Humatrope cartridges are placed in the pen for reconstitution and subsequent injection. Humatrope cartridges must be refrigerated before reconstitution and can be reused, if refrigerated, for up to 28 days following reconstitution. When changing cartridge size/strength patients must get a new pen to match the new cartridge size/strength; they are not interchangeable. The pen device can be used for up to three years after first use. The cartridges should not be used if the patient is allergic to metacresol or glycerin. Only the diluent that is supplied with the cartridges should be used.

Norditropin is supplied as a prefilled pen (NordiFlex and FlexPro). Reconstitution is not necessary; the drug is already in solution. Norditropin pens must be refrigerated prior to initial use. After the initial injection, the pens may be either stored in the refrigerator and used within four weeks or stored for up to three weeks at room temperature.

Nutropin AQ is available in a pen cartridge and Nuspin injection device (multi-dose; dial-a-dose). Nutropin AQ pen cartridge and Nuspin injection must always be refrigerated, before initial use and for 28 days afterward.

Omnitrope® Pen 5 and Omnitrope® Pen 10 use a cartridge containing drug already in solution. The cartridge is loaded into the pen, where it remains until empty. Following the first use, the cartridge and pen can be refrigerated for up to 28 days. Omnitrope cartridges should be refrigerated prior to the initial use, as well.

Needle-free devices for SC administration of Saizen (cool.click®2) and for Serostim (SeroJet®) are available at no extra cost. The cool.click 2 is designed to be used with Saizen and Serostim vials. The click.easy device is an internal reconstitution mechanism; the resulting solution is administered with the easypod® which hides the injection needle. When placed at a 90-degree angle to the injection site, the injection button will turn green when ready. When pressed, the injection button light will go off and the device will beep twice, indicating that the injection was completed. The easypod tracks the remaining drug in the cartridge and its expiration date, the daily dose to administer, and the time and date of the last dose. The entire device can be stored in the refrigerator and cartridges may be stored for up to 21 days. With Serostim, reconstitution of the growth hormone solution is still done through a lengthy manual process prior to drawing it into the administration device. Reconstituted Saizen and multi-use Serostim vials must be refrigerated until used with the remainder discarded after 14 days. Single-use Serostim should be used immediately after reconstitution and any remaining drug should be discarded. Serostim and Saizen can both be stored at room temperature prior to initial use.

Tev-Tropin's Tjet® provides a needle-free alternative by delivering the medication via a rapid-pulse fluid stream when using the 5 mg product. The Tjet method of administration has demonstrated itself to be bioequivalent to traditional needle delivery. The dose must be drawn from the vial into the device, through an adaptor, before administration.⁹⁰

All injection devices have dial-a-dose capabilities. Zorbtive is not currently available with administration devices. Evaluation of patient preferences (with possible increases in compliance) may place added value on one delivery system over another.

CLINICAL TRIALS

Studies were identified through searches performed on PubMed and review of information sent by manufacturers. Search strategy included the FDA-approved use of all brand names in this class. Randomized, comparative, controlled trials performed in the United States comparing agents within this class in an outpatient setting for the approved indications are considered the most relevant in this category. Studies included for analysis in the review were published in English, performed with human participants, and randomly allocated participants to comparison groups. In addition, studies must contain clearly stated, predetermined outcome measure(s) of known or probable clinical importance, use data analysis techniques consistent with the study question, and include follow-up (endpoint assessment) of at least 80 percent of participants entering the investigation. Despite some inherent bias found in all studies, including those sponsored and/or funded by pharmaceutical manufacturers, the studies in this therapeutic class review were determined to have results or conclusions that do not suggest systematic error in their experimental study design. While the potential influence of manufacturer sponsorship and/or funding must be considered, the studies in this review have also been evaluated for validity and importance.

There are no studies meeting the inclusion criteria.

SUMMARY

The currently available growth hormone replacement products are, by definition, similar in their clinical effects. The differences in FDA-approved indications reflect only that the manufacturer of a specific product has pursued approval for those particular indications. No head-to-head data are available.

Most growth hormone products are given six or seven times weekly. Saizen and Tev-Tropin can be given to pediatric patients as few as three times per week, as can Nutropin when treating Turner syndrome. Dose frequency, injection site discomfort, and dosing devices may be a factor in patient compliance with the prescribed regimen.

Other than slight pharmaceutical differences, no pharmacologic difference among the agents exists in terms of safety and efficacy.

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