Mass General Brigham
Health Plan

Somavert (pegvisomant)
Effective 06/01/2023

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions			

Overview
Somavert (pegvisomant) is indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option.

Coverage Guidelines
Authorization may be granted for new members to the plan who are currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

1. Member has a diagnosis of acromegaly
2. Physician documentation that member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
3. Member meets ONE of the following:
    a. Member had an inadequate or partial response to surgery or radiotherapy
    b. There is a clinical reason why the member has not had surgery
4. Member has had inadequate response, intolerable adverse event, or contraindication to Sandostatin LAR and Somatuline Depot

<u>Continuation of Therapy</u>
Reauthorization requires physician documentation for continuation of therapy when the member's IGF-1 level has decreased or normalized since initiation of therapy.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.

References

1. Somavert [package insert]. New York, NY: Pharmacia & Upjohn Company LLC; August 2021.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014; 99:3933-3951.
3. American Association of Clinical Endocrinologists Acromegaly Guidelines Task Force. Medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. Endocr Pract. 2011;17(suppl 4):1-44.

Review History

03/15/2023 – Created and Reviewed for March P&T; switched from CVS SGM criteria to custom. Added preferred drugs of Sandostatin LAR and Somatuline Depot as prerequisite prior to Signifor LAR. Effective 6/1/23