

Somavert (pegvisomant)
Effective 06/01/2023

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| Plan | <input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange | Program Type | <input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy |
| Benefit | <input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit | | |
| Specialty Limitations | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. | | |
| Contact Information | Medical and Specialty Medications | | |
| | All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 |
| | Non-Specialty Medications | | |
| | All Plans | Phone: 800-711-4555 | Fax: 844-403-1029 |
| Exceptions | N/A | | |

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

Continuation of Therapy

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

