

Palsonify (paltusotine)
 Effective 05/01/2026

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 type="checkbox"/> Medical Benefit		
Specialty Limitations	These medications have been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview

Palsonify (paltusotine) is a somatostatin receptor agonist indicated for the treatment of adults with acromegaly who had an inadequate response to surgery and/or for whom surgery is not an option.

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted when all of the following criteria are met:

1. Diagnosis of acromegaly
2. Submission of laboratory report indicating member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range
3. Submission of medical records (e.g., chart notes) indicating ONE of the following
 - a. Member has had an inadequate or partial response to surgery
 - b. Member is not a candidate for surgery
4. Requested medication is prescribed by or in consultation with an endocrinologist
5. Trial and failure, inadequate response, or intolerance to ONE of the following:
 - a. Sandostatin LAR
 - b. Mycapssa
 - c. Somatuline Depot

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Submission of laboratory reports or chart notes indicating member's IGF-1 level has decreased or normalized since initiation of therapy.

Limitations

1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply

Drug Name and Dosage	Quantity Limit
Palsonify tablet	2 tablets per day

References

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2. Fleseriu M, Auchus R, Bancos I, et al. Consensus on diagnosis and management of Cushing's Disease: a guideline update. *Lancet Diabetes Endocrinol*. 2021b;9(12):847-875. doi:10.1016/S2213-8587(21)00235-7
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14. Trainer PJ, Drake WM, Katznelson L, et al. Treatment of acromegaly with the growth hormone-receptor antagonist pegvisomant. *N Engl J Med*. 2000;342:1171-1177.

Review History

02/11/2026 – Reviewed at February P&T. Effective 05/01/2026.

