Mass General Brigham
Health Plan

Somavert (pegvisomant)
Effective 01/01/2026

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has 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
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 within the past 90 days 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. 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.

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. Somavert [package insert]. New York, NY: Pharmacia & Upjohn Company LLC; August 2021.

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
10/08/2025 – Reviewed at October P&T. Updated policy to indicate it no longer applies to the medical benefit. Effective 01/01/2026.