Mass General Brigham
Health Plan

Somavert (pegvisomant)
Effective 05/01/2026

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
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 for members when all 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 chart notes indicating ONE of the following:
    a. Member had an inadequate or partial response to surgery or radiotherapy
    b. Clinical reason why the member has not had surgery
4. Member has had inadequate response, intolerable adverse event, or contraindication to BOTH of the following:
    a. Sandostatin LAR
    b. Somatuline Depot

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when the following criteria are met:

1. Submission of laboratory reports or chart notes indicating 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.
2. The following quantity limitations apply:

Drug name and Dosage Form	Quantity Limit
Somavert vial	1 vial per day

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 (pegmisovant) [prescribing information]. New York, NY: Pharmacia & Upjohn Company LLC; July 2023.

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.
02/11/2026 – Reviewed and updated at February P&T. Updated initial criteria to require documentation of elevated IGF-1 levels and inadequate response to surgery or radiotherapy. Added quantity limit. Effective 05/01/2026.