Mass General Brigham Health Plan

Acromegaly, Carcinoid, Cushing Syndrome Agents
Somavert (pegvisomant)
Signifor LAR (pasireotide injectable suspension)
Effective 10/01/2025

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Somavert (pegvisomant) is also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview

Somavert is indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate.

Signifor LAR is indicated for:

- the treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option.
- the treatment of patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan 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:

Signifor LAR (pasireotide injectable suspension)

Cushing's disease

1. Diagnosis of Cushing's disease
2. **ONE** of the following:
    a. Member has failed surgical intervention (reoccurrence after surgery or failed tumor removal)
    b. Member is not a candidate for surgery
3. Inadequate response, adverse reaction to ONE, or contraindication to ALL of the following:
    a. cabergoline
    b. ketoconazole tablet
    c. Lysodren (mitotane)

d. Metopirone (metyrapone)
4. Quantity requested is ≤ 1 kit or vial/30 days

Acromegaly
1. Diagnosis of acromegaly
2. Prescriber is an endocrinologist or consult notes from an endocrinologist are provided
3. **ONE** of the following:
    a. Member has persistent or recurring disease following surgery and/or radiation
    b. Member is not a candidate for surgery
4. **ONE** of the following:
    a. Inadequate response or adverse reaction to one somatostatin analog that does not require PA
    b. Contraindication to the use of somatostatin analogs
5. **ONE** of the following:
    a. Member has moderate-to-severe disease symptoms
    b. Member has mild disease and **ONE** of the following:
        i. Inadequate response or adverse reaction to one dopamine analog (e.g., cabergoline, bromocriptine) in combination with a somatostatin analog for overlap of 3 months within a 6 month period
        ii. Adverse reaction to one somatostatin analog that does not require PA
        iii. Contraindication to the use of dopamine analogs
6. Quantity requested is ≤ 1 kit or vial/30 days

Somavert (pegvisomant)
1. Diagnosis of acromegaly
2. Prescriber is an endocrinologist or consult notes from an endocrinologist are provided
3. **ONE** of the following:
    a. Member has persistent or recurring disease following surgery and/or radiation
    b. Member is not a candidate for surgery
4. **ONE** of the following:
    a. Inadequate response or adverse reaction to one somatostatin analog that does not require PA
    b. Contraindication to the use of somatostatin analogs
5. **ONE** of the following:
    a. Member has moderate-to-severe disease symptoms
    b. Member has mild disease and **ONE** of the following:
        i. Inadequate response or adverse reaction to one dopamine analog (e.g., cabergoline, bromocriptine) in combination with a somatostatin analog for overlap of 3 months within a 6 month period
        ii. Adverse reaction to one somatostatin analog that does not require PA
        iii. Contraindication to the use of dopamine analogs
6. Quantity requested is ≤ 1 vial/day

<u>Continuation of Therapy</u>
Reauthorization by physician will infer a positive response to therapy.

Limitations

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

References

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15. FDA Approves New Treatment for Adults with Cushing's Disease [press release on the internet]. Silver Spring (MD): Food and Drug Administration; 2020 Mar 6 [cited 2020 May 4] Available from: https://www.fda.gov/news-events/press-announcements/fda-approves-new-treatment-adults-cushings-disease.

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Review History

11/16/2022 – Created for Nov P&T. Matched MH UPPL. The following medications will require a prior authorization on the pharmacy benefit: Somavert, Signifor, Signifor LAR. Combined Mycapssa, Xermelo, Isturisa, Korlym, and Signifor LAR agents and matched MH UPPL criteria. Effective 2/1/23
5/15/25 – Reviewed and updated for P&T. Updated header to differentiate MB drugs vs Rx drugs in this class. Medical criteria remains. Pharmacy criteria was removed and can be accessed via MHDL. Effective 6/1/25
9/10/25 – Reviewed and updated for P&T. Verbiage update regarding member not being a candidate for surgery and prescriber specialty. Effective 10/1/25