PHARMACY PRE-AUTHORIZATION CRITERIA

ConnectiCare

DRUG	**Somavert (pegvisomant injection)**
POLICY #	**21109**
INDICATIONS	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. The goal of treatment is to normalize serum IGF-I levels.
CRITERIA	Coverage of pegvisomant is recommended in those who meet one of the following criteria: 1. Treatment prescribed by an endocrinologist **AND** 2. Pegvisomant is indicated for the treatment of acromegaly. 3. The requesting physician has documented that the member has had a failure of, or is unable to tolerate, a treatment regimen that included octreotide (Sandostatin). 4. The requesting physician has documented that the member is not a candidate for surgery and/or radiation, or has had inadequate response to surgery and/or radiation. **OR** 5. Treatment of excess growth hormone associated with McCune-Albright syndrome.
LIMITATIONS	1. The quantity is limited to a maximum of a 30-day supply per fill. 2. Member is 18 years of age or older
REFERENCES	1. Somavert® injection [package insert]. Kalamazoo, MI: Pharmacia and Upjohn Company. 2. Protocol # 01-D-0197. A study of the effects of pegvisomant on growth hormone excess in McCune-Albright syndrome. Available at: http://clinicalstudies.info.nih.gov/detail/B_2001-D-0197.html.
P&T REVIEW HISTORY	6/07, 6/08, 9/09, 9/10, 12/11, 10/12, 10/13, 10/14, 11/15, 2/17, 1/18
REVISION RECORD	2/17, 4/2020 (added age restriction)