

## PHARMACY POLICY STATEMENT

### Georgia Medicaid

DRUG NAME	Somavert (pegvisomant)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT—30 single dose vials per 30 days
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Somavert (pegvisomant) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### ACROMEGALY

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has diagnosis of uncontrolled acromegaly confirmed by insulin-like growth factor (IGF-1) elevation above normal (lab report required); AND
4. Member had an inadequate response to surgery or radiation, or member is ineligible for these treatments (documentation required); AND
5. Member remains uncontrolled (persistent IGF-1 elevation) after optimized treatment with octreotide or lanreotide for at least 3 months (*NOTE: Somavert may be used in combination with octreotide or lanreotide if member had a partial response (as opposed to no response) after 3 months; cabergoline is another option that may be added instead and does not require prior auth); AND*
6. Member has had baseline liver function testing.
7. **Dosage allowed:** Loading dose 40mg subQ under provider supervision. Titrate to normalize IGF-1; dosing range 10mg-30mg subQ once daily.

***If member meets all the requirements listed above, the medication will be approved for 3 months.***

For **reauthorization**:

1. Chart notes/lab report must show normalized or improved (decreased) IGF-1.

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

**CareSource considers Somavert (pegvisomant) not medically necessary for the treatment of diseases that are not listed in this document.**

DATE	ACTION/DESCRIPTION
11/02/2020	New policy for Somavert created.

References:

1. Somavert (pegvisomant) [package insert]. NY, NY: Pharmacia and Upjohn Co; 2020.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2014;99(11):3933-3951. doi:10.1210/jc.2014-2700
3. Melmed S, Bronstein MD, Chanson P, et al. A Consensus Statement on acromegaly therapeutic outcomes. *Nature Reviews Endocrinology*. 2018;14(9):552-561. doi:10.1038/s41574-018-0058-5
4. Zahr R, Fleseriu M. Updates in Diagnosis and Treatment of Acromegaly. *Eur Endocrinol*. 2018;14(2):57-61. doi:10.17925/EE.2018.14.2.57
5. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary*. October 2020. doi:10.1007/s11102-020-01091-7

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