CareSource

PHARMACY POLICY STATEMENT
Indiana 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 **NOT** MEDICALLY NECESSARY	Click Here

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).
6. **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

Effective date: 04/01/2021
Revised date: 11/02/2020