# Pharmacy Drug Policy Checklist

| POLICY NAME | Somavert (pegvisomant) | POLICY # | 2481P |
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## Criteria

### Coverage Criteria for the Treatment of Acromegaly

- ☐ **1.1** Prescribed by an endocrinologist (hormone doctor)
- ☐ **1.2** Diagnosis of acromegaly
- ☐ **1.3** Age 18 years or older
- ☐ **1.4** High Insulin-like Growth Factor (IGF-1) levels for age (lab values are required)
- ☐ **1.5** Documented inadequate response to surgery or radiotherapy or clinical reason why the patient has not had surgery or radiotherapy
- ☐ **1.6** Documented trial and failure or contraindication to Sandostatin LAR and Somatuline Depot