

POLICY NAME

Somavert (pegvisomant)

POLICY #

2481P

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