UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1193-9
Program	Prior Authorization/Notification
Medication	Somavert® (pegvisomant)
P&T Approval Date	7/2016, 7/2017, 7/2018, 7/2019, 7/2020, 7/2021, 7/2022, 7/2023, 7/2024
Effective Date	10/1/2024

1. Background:

Somavert (pegvisomant) is a growth hormone receptor antagonist 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 insulin-like growth factor-I (IGF-I) levels.[1]

2. Coverage Criteria[a]:

A. Acromegaly

1. **Initial Authorization**

a. **Somavert** will be approved based on **both** of the following criteria:

(1) Diagnosis of acromegaly

-AND-

(2) **One** of the following:

(a) Inadequate response to **one** of the following:
i. Surgery
ii. Radiation therapy

-OR-

(b) Not a candidate for **either** of the following:
i. Surgery
ii. Radiation therapy

Authorization will be issued for 12 months.

2. Reauthorization

a. **Somavert** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Somavert therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Step Therapy may be in place.

4. References:

1. Somavert [package insert]. New York, NY: Pfizer Inc.; July 2023.

Program	Prior Authorization/Notification – Somavert® (pegvisomant)
Change Control	
7/2016	New program
7/2017	Annual review. No changes to the program.
7/2018	Annual review. No changes to the program.
7/2019	Annual review. No changes to the program.
7/2020	Annual review. No changes to coverage criteria.
7/2021	Annual review. No changes to coverage criteria.
7/2022	Annual review. Added state mandate with no other changes to coverage criteria. Reference updated.
7/2023	Annual review. No changes to coverage criteria.
7/2024	Annual review with no changes to coverage criteria. Updated reference.