UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

| | |
|---|---|
| Program Number | 2023 P 1193-8 |
| 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 |
| Effective Date | 10/1/2023;<br>Oxford only: N/A |

**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]. Pharmacia & Upjohn Co. New York, NY. August 2021.

| 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. |