blue of california

pegvisomant (SOMAVERT)

Diagnosis Considered for Coverage:

- Acromegaly

Coverage Criteria:

For diagnosis of acromegaly:

- Being prescribed by or in consultation with an endocrinologist, **and**
- Inadequate response or intolerable side effect to octreotide or lanreotide (Somatuline), **and**
- One of the following:
  - Patient had an inadequate response or contraindication for to surgery, or
  - Patient had an inadequate response to radiation, or
  - Patient is not a candidate for both surgery and radiation,

  and
- Dose does not exceed 40 mg loading dose, followed by 30 mg given via SQ once per day.

Coverage Duration: one year

References:

1. Somavert (pegvisomant) [Prescribing Information]. New York, NY: Pharmacia & Upjohn Company LLC; 8/2021.
2. DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. AHFS-DI®. Available by subscription at https://www.wolterskluwer.com/en/solutions/lexicomp

American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice For the Diagnosis and Treatment of Acromegaly – 2011 update. Endocrine Practice 2011;17(Suppl 4):1-44.

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