Criteria-Based Consultation Prescribing Program
CRITERIA FOR DRUG COVERAGE
Pegvisomant (Somavert)

Initiation (new start) criteria: Non-formulary **pegvisomant (Somavert)** will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescribed by an endocrinologist
- Diagnosis of acromegaly by:
  - Serum GH level more than 1 ng/mL after a 2-hour oral glucose tolerance test at time of diagnosis **-OR-**
  - Elevated serum insulin growth factor 1 (IGF-1) levels which are above the age and gender adjusted normal range at time of diagnosis
- Inadequate response to one of the following:
  - Surgery **-OR-**
  - Radiation therapy **-OR-**
  - Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

  -OR-
- Patient is not a candidate for surgery, radiation therapy, dopamine agonist (e.g., bromocriptine, cabergoline) therapy.
- Inadequate response, intolerance, or contraindication to one of the following somatostatin analogs:
  - Sandostatin (octreotide) or Sandostatin LAR (octreotide) **-OR-**
  - Somatuline Depot (lanreotide)

  -OR-
- Patient is currently on pegvisomant therapy for acromegaly

Continued use criteria (12 months after initiation): Non-formulary **pegvisomant (Somavert)** will continue to be covered for 12 months on the prescription drug benefit when the following criteria are met:

- Documentation of positive clinical response to pegvisomant therapy

  -OR-
- Serum IGF-1 level has decreased from baseline (at time of initial diagnosis) or is within normal limits