SOMAVERT (Pegvisomant)

Coverage Criteria: Somavert is covered for members with a confirmed diagnosis of acromegaly who have not adequately responded to at least two of the following treatments: octreotide (Sandostatin), surgery or radiation therapy.

PLEASE SEND COMPLETED FORM TO COVENTRY HEALTH CARE – PHARMACEUTICAL SERVICES

FAX:Q3 (877) 554-9139 PHONE: (877) 215-4098

Requesting Physician:	Office Contact:
Call Center ID: Tax ID Number:	Plan ID: Benefit:
Office Fax Number:	Phone Number:
Office Address:	

MEMBER INFORMATION

Patient Name:	DOB:
Member ID#:	Date of Request: May 2, 2008

MEDICATION INFORMATION

1.	Is this a NEW START or a continuation of therapy? ☐ New Start *(go to #2)* ☐ Continuation *(go to #8)*
2.	Is the diagnosis documented as ACROMEGALY that has been diagnosed with GH levels with a glucose tolerance test or elevated IGF-I levels? ☐ Yes ☐ No
3.	What is the patient's current GH level? (include normal range)
4.	What is the patient's current IGF-I level? (include normal range)
5.	Has the patient failed at least **two** of the following treatments? ☐ Yes ☐ No *Please check from the following* ☐ Octreotide (Sandostatin) therapy ☐ Surgery ☐ Radiation Therapy ☐ Other
6.	Have baseline liver function tests been performed and the values are less than 3 times the upper limit of normal? ☐ Yes ☐ No
7.	Please submit progress notes related to request and include any additional comments:
	STOP HERE AND SIGN FORM
8.	What date did the patient begin therapy with Somavert?
9.	Has the patient received additional liver function tests and the values are less than 5 times the upper limit of normal? ☐ Yes ☐ No
10.	Have the patient's IGF-I levels been measured? ☐ Yes ☐ No
11.	If yes to #10 above, what is the patient's current IGF-I level? (include normal range)
12.	Please submit progress notes related to patient's response to therapy and include any additional comments:

Note*:* Initial approvals will be granted for 12-months and are subject to a quantity limitation sufficient for a 30-day supply per fill based on FDA-approved dosages. Dosage regimens that exceed 30 mg per day require a letter of medical necessity. Subsequent approvals are based on submitted documentation of positive therapeutic response.

Requesting physician signature: _____

Please indicate specialty:

CHCH 9126-3 (04/08)