



# 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? <input type="checkbox"/> New Start (go to #2) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>two</b> of the following treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please check from the following</i> <input type="checkbox"/> Octreotide (Sandostatin) therapy <input type="checkbox"/> Surgery <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Other
6.	Have baseline liver function tests been performed and the values are less than 3 times the upper limit of normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have the patient's IGF-I levels been measured? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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