Prescription Drug Coverage Determination Form
Growth Hormone Receptor Antagonist
Somavert® (pegvisomant)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information
Patient Name: ________________ Date of Birth:___________________
Subscriber ID#: ___________________
Address_______________________City_______________State____Zip Code________

Physician Information
Name: ______________________ Specialty:____________Tax ID#: _______________
Office Address_______________________City__________State____Zip Code________
Telephone: _________________ Fax:__________________Contact Person___________

Physician Signature (REQUIRED):_____________________________Date___________

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)
Medication name:___________________ J-code:______________
Dose:_________________________________ Directions:_________________________
Expected Duration of Therapy:______________________

Prior Authorization Criteria:

1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? □ Yes □ No
   Diagnosis: _____________________________ ICD-9 code_______________
2. Has the patient received treatment with Somavert® for the past 6 months? □ Yes □ No
   If yes:
   - Has the patient demonstrated a significant decrease in insulin-like growth factor-1 (IGF-1) level with Somavert® therapy? □ Yes □ No
3. Has the patient received any of the following therapies for acromegaly: surgery, radiation therapy, or medical treatment? □ Yes □ No
   If yes;
   - Did the patient have an inadequate response to therapy, or has the physician considered treatments other than Somavert® for acromegaly but rejected as inappropriate? □ Yes □ No
4. Prior to initiation of therapy, did the patient have an insulin-like growth factor-1 (IGF-1) level above the age and gender adjusted normal range? □ Yes □ No
5. Will the patient have IGF-1 levels monitored at 6 months intervals after IGF-1 levels stabilize within normal range? □ Yes □ No

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6. Will the liver function test be monitored as recommended during therapy?	□ Yes □ No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): ____

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Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.