Prescriber Criteria Form Somavert 2025 PA Fax 564-A v1 010125.docx Somavert (pegvisomant) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Somavert (pegvisomant).

Drug Name: Somavert (pegvisomant)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of acromegaly? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient's insulin-like growth factor-1 (IGF-1) level decreased or normalized since initiation of therapy? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a high pre-treatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range? [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient meet any of the following criteria: A) patient had an inadequate or partial response to surgery or radiotherapy, B) there is a clinical reason for why the patient has not had surgery or radiotherapy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____