



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

SOMAVERT (Pegvisomant)

Coverage Criteria / Required Medical Information

Prescriber is an Endocrinologist.

Diagnosis of Acromegaly **and** elevated IGF-1 level **or** elevated GH level with a glucose tolerance test **and** patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline.

Retreatment: reduction in IGF-1 level from baseline

Exclusion Criteria

IV administration of Somavert; concomitant use of Sandostatin or Somatuline.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

SOMAVERT	Reason for Request				
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage
What is the patient's current IGF-I level? (include normal range)	
Formulary Alternative(s) Attempted?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Please List Alternative Formulary Drugs	

Comments	
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Physicians Signature: _____

Fax Form to 1-866-481-3704