UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SOMAVERT (pegvisomant)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- **DOCUMENTED** acromegaly.
- **DOCUMENTATION** showing inadequate response to either transsphenoidal adenomectomy or radiotherapy or both.
- **DOCUMENTED** trial on at least one Dopamine agonist such as cabergoline (Dostinex) or bromocriptine.
- **DOCUMENTATION** that patient has been evaluated for a somatostatin analogue such as octreotide acetate (sandostatin).

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Updated letter of medical necessity