Clinical Policy: Pegvisomant (Somavert)

Reference Number: CP.PHAR.389
Effective Date: 12.01.18
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pegvisomant (Somavert®) is a growth hormone receptor antagonist.

FDA Approved Indication(s)

Somavert is indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate. The goal of treatment is to normalize serum insulin-like growth factor-I (IGF-I) levels.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results, or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Somavert is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acromegaly (must meet all)**:**

1. Diagnosis of acromegaly as evidenced by one of the following (a or b):
   a. Pre-treatment IGF-I level above the upper limit of normal based on age and gender for the reporting laboratory;
   b. Serum growth hormone (GH) level ≥ 1 µg/L after a 2-hour oral glucose tolerance test;
2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 18 years;
4. Inadequate response to surgical resection or pituitary irradiation (*see Appendix D*), or member is not a candidate for such treatment;
5. Failure of both of the following^, unless clinically significant adverse effects are experienced or all are contraindicated (a and b);*
   **For Illinois HIM requests, the step therapy requirement below does not apply as of 1/1/2026 per IL HB 5395*
   a. Lanreotide (Somatuline® Depot);
   b. Both of the following (i and ii):
      i. Generic octreotide acetate LAR (generic Sandostatin® LAR Depot), unless octreotide acetate LAR is unavailable due to shortage;
      ii. If member is unable to use generic octreotide acetate LAR (generic Sandostatin LAR Depot) due to shortage: Sandostatin LAR Depot;

   ^Prior authorization may be required for lanreotide, octreotide acetate LAR, and Sandostatin LAR Depot

6. Dose does not exceed both of the following (a and b):
   a. Loading dose: 40 mg once;
   b. Maintenance dose: 30 mg per day.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Acromegaly (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively therapy (*see Appendix D*);
3. If request is for a dose increase, new dose does not exceed 30 mg per day.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GH: growth hormone
IGF: insulin-like growth factor
SRL: somatostatin receptor ligand

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
octreotide acetate (Sandostatin LAR Depot) [IM]	20-40 mg IM every 4 weeks	See dosing regimen
lanreotide (Somatuline Depot)	90-20 mg SC every 4 weeks	See dosing regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Recommendations from the 13th Acromegaly Consensus Conference (*Guistina 2020*) include:
  - Somatostatin receptor ligands (SRLs) such as octreotide LAR and lanreotide are used as first-line medical therapy due to their favorable risk/benefit profiles.
  - Pegvisomant is generally used as second-line therapy in patients who do not achieve biochemical control with maximal doses of SRL therapy.

- Examples of treatment response to acromegaly therapy (including somatostatin analogs, surgical resection, or pituitary irradiation) include improvement from baseline in or normalization of GH and/or age- and sex-adjusted IGF-I serum concentrations, or tumor mass control.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Acromegaly	Loading dose: 40 mg SC under healthcare provider supervision Maintenance dose: 10 to 30 mg SC QD	Maintenance: 30 mg/day

VI. Product Availability

Single-use vials with powder for reconstitution: 10 mg, 15 mg, 20 mg, 25 mg, 30 mg

VII. References

1. Somavert Prescribing Information. New York, NY: Pfizer Pharmacia & Upjohn Co; July 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021106s074lbl.pdf. Accessed on July 10, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed September 3, 2026.
3. Melmed S, Bronstein MD, Chanson P. A Consensus Statement on acromegaly therapeutic outcomes. Nat Rev Endocrinol. 2018 Sep;14(9):552-561. doi: 10.1038/s41574-018-0058-5.
4. Katznelson L, Laws Jr. ER, Melmed S, et al. Acromegaly: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014;99:3933-3951.
5. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 7, 2025.
6. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. Pituitary. 2021; 24: 1-13.
7. Giustina A, Biermasz N, Casanueva FF, et al; Acromegaly Consensus Group (ACG). Consensus on criteria for acromegaly diagnosis and remission. Pituitary. 2024 Feb;27(1):7-22. doi: 10.1007/s11102-023-01360-1.
8. Guistina A, Barkhoudarian G, Beckers A, et al. Multidisciplinary management of acromegaly: A consensus. Rev Endocr Metab Disord. 2020; 21(4): 667-678.
9. Melmed S, di Filippo L, Fleseriu M, et al. Consensus on acromegaly therapeutic outcomes: An update. Nature Reviews Endocrinology 2025;21:718-737.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3590	Unclassified biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: added confirmatory diagnostic requirements (IGF-I or GH) per PS/ES practice guidelines; updated Appendix D with 2020 consensus recommendations; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	07.20.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.03.23	11.23
4Q 2024 annual review: for acromegaly, revised initial criteria from "(GH) level ≥ 1 µg/mL" to "(GH) level ≥ **1 µg/L**" per PS/ES practice guidelines and ACG; removed inactive HCPCS code C9399 and updated J3590 HCPCS code description to "unclassified biologics"; references reviewed and updated.	07.15.24	11.24
4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; for initial therapy, extended duration from 6 months to 12 months for HIM and Medicaid; references reviewed and updated.	07.10.25	11.25
Per December SDC, revised somatostatin analog redirection to failure of all of the following: lanreotide, octreotide acetate LAR (generic Sandostatin LAR Depot), and brand Sandostatin LAR Depot if octreotide acetate LAR (generic Sandostatin LAR Depot) is unavailable due to shortage.	12.04.25	02.26
4Q 2026 annual review: no significant changes; added ICHRA line of business; references reviewed and updated.	07.10.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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