Initial approval criteria: Non-formulary pegvisomant (Somavert®) will be covered for 12 months on the prescription drug benefit when the following criteria are met:

- Prescribed by an endocrinologist
-AND-

- Diagnosis of acromegaly by:
  - Serum GH level > 1 ng/mL after a 2-hour oral glucose tolerance test at time of diagnosis -OR-
  - Elevated serum insulin growth factor 1 (IGF-1) levels which are above the age and gender adjusted normal range at time of diagnosis
-AND-

- Inadequate response to one of the following:
  - Surgery -OR-
  - Radiation therapy -OR-
  - Dopamine agonist (e.g., bromocriptine, cabergoline) therapy
-OR-

- Patient is not a candidate for surgery, radiation therapy, dopamine agonist (e.g., bromocriptine, cabergoline) therapy.
-AND-

- Inadequate response, intolerance, or contraindication to one of the following somatostatin analogs:
  - Sandostatin (octreotide) or Sandostatin LAR (octreotide) -OR-
  - Somatuline Depot (lanreotide)
-OR-

- Patient is currently on pegvisomant therapy for acromegaly

Continued use criteria: Non-formulary pegvisomant (Somavert®) will continue to be covered for 12 months on the prescription drug benefit when the following criteria are met:

- Documentation of positive clinical response to pegvisomant therapy
-OR-

- Serum IGF-1 level has decreased from baseline (at time of initial diagnosis) or is within normal limits