

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 note the new fax number**

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

9/20/10

<http://health.utah.gov/medicaid/pharmacy>