Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

SOMAVERT (Pegvisomant)

Coverage Criteria
Acromegaly

Required Medical Information
Prior to initiation of therapy, IGF-1 levels were above age and gender adjusted normal range. (If patient has been on therapy for the past 6 months, demonstration of significant decrease in IGF-1 levels required.)
Patient was considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but was rejected or had inadequate response.

Exclusion Criteria
Non FDA approved treatment

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:**		**No:**	
Please List Alternative Formulary Drugs				
Comments				

Physicians Signature: ____________________________________ **Fax Form to 1-877-847-9904**