Clinical Policy: Pegvisomant (Somavert)

Reference Number: LA.PHAR.389
Effective Date: 03.16.23
Last Review Date: 12.10.24
Line of Business: Medicaid

Coding Implications
Revision Log

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

****Please note: This is policy for medical benefit****

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 Louisiana Healthcare Connections 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 a somatostatin analog* at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
   **Prior authorization may be required for somatostatin analogs*
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: 6 months

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 LA.PMN.255
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 LA.PMN.53

II. Continued Therapy

A. Acromegaly (must meet all)**:**
a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
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: 12 months

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 LA.PMN.255
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 LA.PMN.53

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 – LA.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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
octreotide (Sandostatin® [SC, IV], Sandostatin® LAR Depot [IM])	**Acromegaly** Initial: 50 mcg SC or IV TID Maintenance: 100 to 500 mcg SC or IV TID For patients stable on SC formulation: patients can switch to 20 mg IM intragluteally every 4 weeks	1,500 mcg/day (SC, IV) 40 mg every 4 weeks (IM)

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	for 3 months, then adjust dose based on clinical response	
Somatuline® Depot (lanreotide)	**Acromegaly** 90 mg SC once every 4 weeks for 3 months, then adjust dose based on clinical response	120 mg once every 4 weeks
Signifor® LAR (pasireotide)	**Acromegaly** 40 mg to 60 mg IM every 4 weeks	60 mg once every 4 weeks

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 15, 2024.
2. 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.
3. Katznelson L, Laws Jr. ER, Melmed S, et al. Acromegaly: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014;99:3933-3951.

4. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed July 25, 2024.
5. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. Pituitary. 2021; 24: 1-13.
6. 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.
7. Guistina A, Barkhoudarian G, Beckers A, et al. Multidisciplinary management of acromegaly: A consensus. Rev Endocr Metab Disord. 2020; 21(4): 667-678.

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	LDH Approval Date
Converted corporate to local policy.	02.23	03.16.23
Updated criteria for other diagnoses/indications	06.25.23	10.05.23
Annual review: no significant changes; references reviewed and updated.	04.16.24	07.10.24
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.	12.10.24	

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. LHCC 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.

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

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