



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Somavert (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Somavert (Medicare Determination).

Drug Name (select from list of drugs shown)

Somavert (pegvisomant)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have a diagnosis of acromegaly? | Y | N |
| 3. Has the patient received therapy with Somavert for the past 6 months?
[If the answer to this question is no, skip to question 5.] | Y | N |
| 4. Has the patient demonstrated a significant decrease in insulin-like growth factor-1 (IGF-1) levels with Somavert therapy?
[If the answer to this question is yes, skip to question 9.] | Y | N |
| 5. Has the patient received any of the following therapies for acromegaly: surgery, radiation therapy, or medical treatment?
[If the answer to this question is no, skip to question 7.] | Y | N |
| 6. Did the patient have an inadequate response to the therapy?
[Skip to question 8.] | Y | N |
| 7. Has the physician considered treatments other than Somavert for acromegaly but rejected as inappropriate? | Y | N |
| 8. Prior to the initiation of therapy, did the patient have insulin-like growth factor-1 (IGF-1) levels above the age and gender | Y | N |



**Arkansas
BlueCross BlueShield**

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adjusted normal range?

- | | | |
|--|---|---|
| 9. Will the patient have IGF-1 levels monitored at 6 month intervals after IGF-1 levels stabilize within the normal range? | Y | N |
| 10. Will liver function tests be monitored as recommended during therapy with Somavert? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date