Nevada Medicaid – Molina Healthcare

Somavert® (pegvisomant)

Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request**. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting brand ❑ Check if request is for initial certification (12 weeks) ❑ Check if request is for recertification of therapy (12 months)	Directions for Use:	

Clinical Information (required)

Provide Diagnosis:

❑ Diagnosis of acromegaly.

❑ Other diagnosis:_____ ICD-10 Code(s): _____

Drug-Specific Information (required)

Inadequate response or not a candidate for (mark all that apply):

- ❑ Surgery
- ❑ Radiation Therapy
- ❑ Dopamine agonist therapy

❑ Trial and failure or contraindication or intolerance to generic octreotide.

❑ Prescribed by or in consultation with an endocrinologist.

❑ For recertification, please provide documentation of positive clinical response to Somavert® therapy such as biochemical control; decrease or normalization of IGF-1 levels.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call (833) 685-2103. This form may be used for non-urgent requests and faxed to (844) 259-1689.