



Somavert® (pegvisomant) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: **1-866-752-7021** (TTY: **711**)
FAX: **1-888-267-3277**

**For Medicare Advantage Part B:
Please Use Medicare Request Form**

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone:	
Email:		Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms Allergies:			

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:		Office Contact Name:			Phone:

Specialty (Check one): Endocrinologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for: Somavert (pegvisomant)
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required):
Acromegaly
 Yes No Has the patient had an inadequate or partial response to surgery or radiotherapy?
↳ Yes No Is there a clinical reason why the patient has not had surgery or radiotherapy?
Please indicate the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compared to the laboratory's reference normal range based on age and/or gender:
 IGF-1 level is higher than the laboratory's normal range
 IGF-1 level is lower than the laboratory's normal range
 IGF-1 level falls within the laboratory's normal range

For Continuation Requests (clinical documentation required):
Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
 IGF-1 level has increased IGF-1 level has decreased or normalized IGF-1 level has not changed

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.