UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1505-1
Program	Prior Authorization/Notification
Medication	Palsonify™ (paltusotine)
P&T Approval Date	12/2025
Effective Date	3/1/2026

1. Background:

Palsonify (paltusotine) is a somatostatin receptor agonist indicated for the treatment of adults with acromegaly who had an inadequate response to surgery and/or for whom surgery is not an option.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Palsonify** will be approved based on **all** of the following criteria:

   a. Diagnosis of acromegaly

   -AND-

   b. Patient is ≥ 18 years old

   -AND-

   c. **One** of the following:

      (1) Inadequate response to surgery

      -OR-

      (2) Patient is not a candidate for surgery

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Palsonify** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Palsonify therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- Medical Necessity may be in place.

4. References:

1. Palsonify [package insert]. San Diego, CA: Crinetics Pharmaceuticals, Inc.; September 2025.

Program	Prior Authorization/Notification – Palsonify™ (paltusotine)
Change Control	
12/2025	New program