Sandostatin LAR Depot (octreotide acetate)
Somatuline Depot (lanreotide acetate)
Lanreotide Acetate Injection (lanreotide acetate)
Signifor LAR (pasireotide)
Somavert (pegvisomant)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of this drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies while steering utilization to the most cost-effective medication. When requesting treatment of acromegaly, Sandostatin LAR Depot and Somatuline Depot are the preferred products. The criteria will require the use of the health plan's preferred products before the use of the targeted products, Signifor LAR and Somavert, for members who are new to treatment with the non-preferred product for a diagnosis of acromegaly and provides an exception process for non-preferred products through prior authorization.

Sandostatin LAR

FDA-Approved Indications

- Sandostatin LAR Depot is indicated in patients in whom initial treatment with Sandostatin injection has been shown to be effective and tolerated.
    - Indicated for long-term maintenance therapy in acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option.
    - Indicated for long-term treatment of the severe diarrhea and flushing episodes associated with metastatic carcinoid tumors.
    - Indicated for long-term treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors.

Compendial Uses

- Neuroendocrine tumors (NETs):
    - Tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)
    - Tumors of the pancreas
- Pheochromocytoma and paraganglioma
- Thymomas and thymic carcinomas
- Acquired immune deficiency syndrome (AIDS)-associated diarrhea
- Inoperable bowel obstruction
- Chemotherapy- and radiation-induced diarrhea
- Enterocutaneous fistula
- Gastroesophageal varices
- Islet cell tumors
- Pancreatic fistulas
- Pituitary adenoma
- Short bowel syndrome
- Zollinger-Ellison syndrome

Somatuline Depot & Lanreotide Injection

FDA-Approved Indications

1. Somatuline Depot
    a. Long-term treatment of acromegalic patients who have had an inadequate response to surgery and/or radiotherapy.
    b. Treatment of adult patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival.
    c. Treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy.

2. Lanreotide Injection
    a. Long-term treatment of acromegalic patients who have had an inadequate response to surgery and/or radiotherapy.
    b. Treatment of adult patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival.

Compendial Uses

- Neuroendocrine tumors (NETs):
    - Tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)
    - Tumors of the pancreas (islet cell tumors)
    - Well-differentiated grade 3 NETs with favorable biology
- Pheochromocytoma and paraganglioma
- Zollinger-Ellison syndrome

Signifor LAR

FDA-Approved Indications

- Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option
- Treatment of patients with Cushing’s disease for whom pituitary surgery is not an option or has not been curative

Somavert

FDA-Approved Indications

- 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.

Table. Acromegaly Products

Medication	Generic Name
Preferred Products:	
Somatuline Depot	lanreotide
Sandostatin LAR Depot	octreotide acetate for injectable suspension
Targeted Products:	
Signifor LAR	Pasireotide
Somavert	pegvisomant

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Sandostatin LAR Depot

A. For acromegaly:
   1. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or radiotherapy or a clinical reason for not having surgery or radiotherapy.
   2. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy
B. Chemotherapy- and radiation-induced diarrhea: Chart notes indicating grade 3 or 4 diarrhea with current chemotherapy or radiation.

Somatuline Depot and Lanreotide Injection

Submission of the following information is necessary to initiate the prior authorization review for acromegaly:

A. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or radiotherapy or a clinical reason for not having surgery or radiotherapy.
B. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy

Signifor LAR

A. For acromegaly:
   1. Chart notes documenting inadequate response to or an intolerable adverse event to both preferred products
   2. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or a clinical reason for not having surgery.
   3. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy
B. Cushing's disease:
   1. For initial requests, pretreatment cortisol level as measured by one of the following tests:
      a. Urinary free cortisol (UFC) level
      b. Late night salivary cortisol
      c. 1 mg overnight dexamethasone suppression test (DST)

d. Longer, low dose DST (2mg per day for 48 hours)
2. For continuation of therapy, current cortisol level as measured by one of the following tests:
   a. Urinary free cortisol (UFC) level
   b. Late-night salivary cortisol
   c. 1 mg overnight dexamethasone suppression test (DST)
   d. Longer, low dose DST (2mg per day for 48 hours)

Somavert

A. Chart notes documenting inadequate response to or an intolerable adverse event to both preferred products
B. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or radiotherapy or a clinical reason for not having surgery or radiotherapy
C. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design

A. Coverage for a non-preferred product is provided when ANY of the following criteria is met:
   1. Member has acromegaly and has had an inadequate response to or an intolerable adverse event to any of the preferred products, Somatuline Depot and Sandostatin LAR.

This preferred drug program only applies to members requesting treatment for the indication, acromegaly, that is FDA-approved for both of the preferred products.

Criteria for Initial Approval

Sandostatin LAR Depot

A. **Acromegaly**
   Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
   1. Member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
   2. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy.
   3. For Mycapssa requests, member has previously responded to and tolerated treatment with octreotide or lanreotide.

B. **Neuroendocrine tumors (NETs) (injectable products only)**
   1. Tumors of the gastrointestinal (GI) tract (carcinoid tumor)
      Authorization of 12 months may be granted for treatment of locoregional advanced or metastatic NETs of the GI tract or unresected primary gastrinoma.
   2. Tumors of the thymus (carcinoid tumor)
      Authorization of 12 months may be granted for treatment of unresectable or metastatic NETs of the thymus.
   3. Tumors of the lung (carcinoid tumor)
      Authorization of 12 months may be granted for treatment of unresectable or metastatic NETs of the lung.
   4. Tumors of the pancreas
      Authorization of 12 months may be granted for treatment of NETs of the pancreas.

C. **Carcinoid syndrome**
   Authorization of 12 months may be granted for treatment of carcinoid syndrome when it is used in any of the following clinical settings:
   1. As a single agent

2. In combination with telotristat for persistent diarrhea due to poorly controlled carcinoid syndrome
3. In combination with other systemic therapy options for persistent symptoms such as flushing or diarrhea, or for progressive disease

D. **Vasoactive intestinal peptide tumors (VIPomas)**
Authorization of 12 months may be granted for management of symptoms related to hormone hypersecretion of VIPomas.

E. **Pheochromocytoma and paraganglioma**
Authorization of 12 months may be granted for treatment of locally unresectable or metastatic pheochromocytoma and paraganglioma.

F. **Thymomas and thymic carcinomas**
Authorization of 12 months may be granted for treatment of thymomas and thymic carcinomas when the requested drug is used as a second-line therapy with or without prednisone in any of the following clinical settings:
1. Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis
2. Extrathoracic metastatic disease

G. **Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy**
Authorization of 6 months may be granted for treatment of CHI and persistent hyperinsulinemic hypoglycemia in an infant.

H. **AIDS-associated diarrhea**
Authorization of 12 months may be granted for treatment of AIDS-associated severe secretory diarrhea when anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine) have become ineffective.

I. **Bowel obstruction in terminal cancer**
Authorization of 12 months may be granted for management of GI symptoms (e.g., nausea, pain, vomiting) of inoperable bowel obstruction in members with terminal cancer.

J. **Chemotherapy- and radiation-induced diarrhea**
Authorization of 12 months may be granted for treatment of chemotherapy- or radiation-induced diarrhea when all of the following criteria are met:
1. Member is receiving treatment with chemotherapy or radiation
2. Member has grade 3 or greater diarrhea according to National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE).

K. **Enterocutaneous fistula**
Authorization of 12 months may be granted for management of volume depletion from enterocutaneous fistula.

L. **Gastroesophageal varices**
Authorization of 6 months may be granted for treatment of acute bleeding of gastroesophageal varices associated with cirrhosis.

M. **Islet cell tumors**
Authorization of 12 months may be granted for stabilization of blood glucose levels in patients with functioning islet cell tumors (e.g., insulinomas or glucagonomas).

N. **Pancreatic fistulas**
Authorization of 6 months may be granted for prevention and treatment of pancreatic fistulas following pancreatic surgery.

O. **Pituitary adenoma**
Authorization of 12 months may be granted for treatment of pituitary adenoma.

P. **Short bowel syndrome**

Authorization of 12 months may be grated for treatment of short bowel syndrome when the daily intravenous fluid requirement is greater than 3 liters.

Q. **Zollinger-Ellison syndrome**
Authorization of 12 months may be grated for treatment of Zollinger-Ellison syndrome.

Somatuline Depot and Lanreotide Injection

A. Acromegaly
Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
1. Member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
2. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy.

B. Neuroendocrine tumors (NETs)
1. Tumors of the gastrointestinal (GI) tract (carcinoid tumor)
   Authorization of 12 months may be granted for treatment of locoregional advanced or metastatic NETs of the GI tract or unresected primary gastrinoma.
2. Tumors of the thymus (carcinoid tumor)
   Authorization of 12 months may be granted for treatment unresectable or metastatic of NETs of the thymus.
3. Tumors of the lung (carcinoid tumor)
   Authorization of 12 months may be granted for treatment of unresectable or metastatic NETs of the lung.
4. Tumors of the pancreas (islet cell tumors)
   Authorization of 12 months may be granted for treatment of NETs of the pancreas.
5. Well-differentiated grade 3 NETS with favorable biology
   Authorization of 12 months may be granted for treatment of well-differentiated grade 3 unresectable locally advanced or metastatic NETs (not of gastroenteropancreatic origin) with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)
6. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
   Authorization of 12 months may be granted for treatment of unresectable, well- or moderately-differentiated, locally advanced or metastatic GEP-NETs.

C. Carcinoid syndrome
Authorization of 12 months may be granted for treatment of carcinoid syndrome when it is used in any of the following clinical settings:
1. As a single agent
2. In combination with telotristat for persistent diarrhea due to poorly controlled carcinoid syndrome
3. In combination with other systemic therapy options for persistent symptoms such as flushing or diarrhea, or for progressive disease

D. Pheochromocytoma and paraganglioma
Authorization of 12 months may be granted for treatment of locally unresectable or metastatic pheochromocytoma and paraganglioma.

E. Zollinger-Ellison syndrome
Authorization of 12 months may be granted for treatment of Zollinger-Ellison syndrome.

Signifor LAR
A. **Acromegaly**
Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
1. Member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
2. Member had an inadequate or partial response to surgery OR there is a clinical reason why the member has not had surgery.

B. **Cushing's disease**
Authorization of 12 months may be granted for the treatment of Cushing's disease when the member has had surgery that was not curative OR the member is not a candidate for surgery.

Somavert
Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:
A. Member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
B. Member had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy.

Continuation of Therapy

Sandostatin LAR Depot
A. **Acromegaly**
Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

B. **Carcinoid syndrome, VIPomas, AIDS-associated diarrhea, bowel obstruction, chemotherapy/radiation-induced diarrhea, islet cell tumors, and Zollinger-Ellison syndrome**
Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when the member is experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy.

C. **All other indications**
All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

Somatuline Depot and Lanreotide Injection
A. **Acromegaly**
Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

B. **Carcinoid syndrome and Zollinger-Ellison syndrome**
Authorization of 12 months may be granted for continued treatment in members requesting reauthorization when the member is experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy.

C. **All other indications**
All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

Signifor LAR
A. **Acromegaly**
Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

B. **Cushing's disease**
Authorization of 12 months may be granted for continuation of therapy for Cushing's disease when the member meets one of the following criteria:
1. Lower cortisol levels since the start of therapy per one of the following tests:
    a. Urinary free cortisol (UFC)
    b. Late-night salivary cortisol
    c. 1 mg overnight dexamethasone suppression test (DST)
    d. Longer, low dose DST (2mg per day for 48 hours)
2. Improvement in signs and symptoms of the disease

Somavert

Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

The aforementioned drugs are considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J2502 – Inj, pasireotide long acting, 1 gm (Signifor LAR)
- J3490/J3590 unclassified drug (Somavert)
- J2353 - Injection, octreotide, depot form for intramuscular injection, 1 mg (Sandostatin LAR)
- J1930 - Injection, lanreotide, 1 mg (Somatuline Depot)
- J1932 - Injection, lanreotide, (cipla) 1mg (effective 10-1-2022)

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POLICY HISTORY

Policy #: 05.02.40
Policy Creation: January 2018
Reviewed: August 2022
Revised: August 2022
Current Effective Date: August 10, 2022