Acromegaly
(Preferred Products: Somatuline Depot, Sandostatin LAR)

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

This policy informs prescribers of preferred products and provides an exception process for non-preferred products through prior authorization.

This program applies to the acromegaly products specified in this policy when used for an indication that is FDA-approved for the preferred product. Coverage for a non-preferred product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with the non-preferred product for a diagnosis of acromegaly.

Table. Acromegaly Products

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

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POLICY

EXCEPTION CRITERIA

Coverage for a non-preferred product is provided when ANY of the following criteria is met:

- Member is currently receiving treatment with the targeted product through health insurance, excluding when the targeted product is obtained as samples or via manufacturer's patient assistance programs.
- Member has had an inadequate response to or an intolerable adverse event to both preferred products, Somatuline Depot and Sandostatin LAR.

This program only applies to members requesting treatment for an indication, acromegaly, that is FDA-approved for the preferred product.

Prior approval is required. Submit a prior approval/treatment request now.

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)

REFERENCES

- Somatuline Depot [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; June 2019.
- Signifor LAR [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Company; April 2019.
- Somavert [package insert]. New York, NY: Pharmacia & Upjohn Co; September 2019.
- Sandostatin LAR Depot [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2019.

POLICY HISTORY

Policy #: 05.02.40
Policy Creation: January 2018
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