Clinical Policy: Lanreotide (Somatuline Depot)

Reference Number: LA.PHAR.391
Effective Date:
Last Review Date: 01.21
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Lanreotide (Somatuline® Depot) is a somatostatin analog.

FDA Approved Indication(s)

Somatuline Depot is indicated for:

- Long-term treatment of acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy
- Treatment of adult patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival
- Treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy

Policy/Criteria

Prior authorization is required. Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that Somatuline Depot is medically necessary when the following criteria are met:

I. Initial Approval Criteria

A. Acromegaly (must meet all):

1. Diagnosis of acromegaly;
2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 18 years;
4. Inadequate response to surgical resection or pituitary irradiation (*see Appendix D*), or member is not a candidate for such treatment;
5. Dose does not exceed 120 mg every 4 weeks.

Approval duration:
Medicaid – 6 months

B. Carcinoid Syndrome (must meet all):

1. Diagnosis of carcinoid syndrome (associated with NETs of the gastrointestinal tract, lung, and thymus, otherwise known as carcinoid tumors);
2. Prescribed by or in consultation with an oncologist;

3. **Age ≥ 18 years;**
4. **Request meets one of the following (a or b):***
   a. **Dose does not exceed 120 mg every 4 weeks;**
   b. **Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).**
   Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:
Medicaid – 6 months

C. Neuroendocrine Tumors (must meet all):
1. **Diagnosis of one of the following (a, b, c, or d):**
   a. **GEP-NET (*see Appendix D for tumor types*);**
   b. **Thymic NET;**
   c. **Bronchopulmonary NET;**
   d. **Pheochromocytoma or paraganglioma (adrenal NETs);**
2. **Prescribed by or in consultation with an oncologist;**
3. **Age ≥ 18 years;**
4. **Request meets one of the following (a or b):***
   a. **Dose does not exceed 120 mg every 4 weeks;**
   b. **Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).**
   Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:
Medicaid – 6 months

D. Other diagnoses/indications
1. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

II. Continued Therapy

A. Acromegaly (must meet all):
1. **Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;**
2. **Member is responding positively to therapy (*see Appendix D*);**
3. **If request is for a dose increase, new dose does not exceed 120 mg every 4 weeks.**

Approval duration:
Medicaid – 12 months

B. Carcinoid Syndrome and Neuroendocrine Tumors (must meet all):
1. **Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Somatuline Depot for a covered indication and has received this medication for at least 30 days;**
2. **If request is for a dose increase, request meets one of the following (a or b):***

a. **New dose does not exceed 120 mg every 4 weeks.**
b. **New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).**

Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration:
Medicaid – 12 months

C. **Other diagnoses/indications (must meet 1 or 2):**
1. **Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.**
Approval duration: Duration of request or 6 months (whichever is less); or
2. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.**

III. Diagnoses/Indications for which coverage is NOT authorized:

A. **Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – LA.PMN.53 for Medicaid or evidence of coverage documents.**

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
GEP: gastroenteropancreatic
NET: neuroendocrine tumor

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
- **Contraindication(s): hypersensitivity to lanreotide**
- **Boxed warning(s): none reported**

Appendix D: General Information
- **Response to acromegaly therapy (e.g., somatostatin analogs, surgical resection, pituitary irradiation) may include:**
  - **Improved growth hormone (GH) or insulin-like growth factor (IGF-1) serum concentrations**
  - **Improved tumor mass control**
- **NCCN guidelines - Neuroendocrine and Adrenal Tumors**
  - **GEP-NETs**
    - **Gastrointestinal tract tumors include the appendix, stomach, colon and rectum, duodenum, ampulla of Vater, jejunum and ileum.**
    - **Pancreatic tumors include insulinoma, gastrinoma, VIPoma (vasoactive intestinal polypeptide), glucagonoma, somatostatinoma.**

- **Patients experiencing disease progression on lanreotide should continue treatment with lanreotide if the tumor is functional. Lanreotide may be used in combination with other systemic therapy options.**

V. Dosage and Administration*

Indication	Dosing Regimen	Maximum Dose
Acromegaly	Initial: 90 mg SC every 4 weeks for 3 months Maintenance: 90 to 120 mg SC every 4 weeks Dose should be adjusted according to reduction in serum GH or IGF-1 levels and/or changes in symptoms.	Maintenance: 120 mg every 4 weeks
GEP-NETs, carcinoid syndrome	120 mg SC every 4 weeks If patients are being treated with Somatuline Depot for both GEP-NET and carcinoid syndrome, do not administer an additional dose	120 mg every 4 weeks

Intended for administration by a healthcare provider

VI. Product Availability

Single-dose prefilled syringes: 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5 mL

VII. References

1. Somatuline Depot Prescribing Information. Signes, France: Ipsen Pharma Biotech; June 2019. Available at: http://www.somatulinedepot.com. Accessed July 27, 2020.
2. Melmed S, Bronstein MD, Chanson P. A Consensus Statement on acromegaly therapeutic outcomes. Nat Rev Endocrinol. 2018 Sep;14(9):552-561. doi: 10.1038/s41574-018-0058-5.
3. Katznelson L, Laws Jr. ER, Melmed S, et al. Acromegaly: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014;99:3933-3951.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 27, 2020.
5. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed July 27, 2020.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1930	Injection, lanreotide, 1 mg

Reviews, Revisions, and Approvals	Date
Converted corporate to local policy	01.21

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.