| Field Name | Field Description |
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| Prior Authorization Group Description | Somatostatin Analogs and Growth Hormone Receptor Antagonists |
| Drugs | Octreotide (Sandostatin)<br>Sandostatin LAR (octreotide)<br>Lanreotide 120 mg/0.5 mL<br>**Lanreotide (**Somatuline Depot**)** ~~(lanreotide)~~ 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5mL<br>Mycapssa (octreotide)<br>Signifor (pasireotide)<br>Signifor LAR (pasireotide)<br>Somavert (pegvisomant) |
| Covered Uses | Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA) Drug Package Insert (PPI).<br><br>** Non-FDA approved (i.e. off-label) uses; refer to the "Oncology Drugs" policy for off-label oncology uses** |
| Exclusion Criteria | N/A |
| Required Medical Information | See "Other Criteria" |
| Age Restrictions | Per FDA approved package insert |
| Prescriber Restrictions | Prescriber must be a specialist with appropriate expertise in treating the condition in question (such as an endocrinologist, neurologist/neurosurgeon, oncologist, etc.). Consultation with appropriate specialist for the condition in question is also acceptable. |
| Coverage Duration | If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months. |
| Other Criteria | ****Drug is being requested through the member's medical benefit****<br><br>**Initial Authorization**<br><br>For all FDA approved indications (including FDA-approved oncology related uses)<br>• Medication requested is for an FDA approved indication and dose<br>• If the provider is requesting therapy with more than one somatostatin analog or a somatostatin analog and a growth hormone receptor antagonist, then documentation must be submitted as to why patient is unable to be treated with monotherapy, or a medical reason was provided why monotherapy is not appropriate.<br><br>For Acromegaly |

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| Revision/Review Date 4/2025~~4~~ | • Patient has had an inadequate response to, or medical reason why, surgical treatment cannot be used.<br>• If the patient mild disease (e.g. mild signs and symptoms of growth hormone excess, modest elevations in IGF-1) there is a documented trial of a dopamine agonist (e.g. bromocriptine mesylate, cabergoline) at a therapeutically appropriate dose or a documented medical reason why a dopamine agonist cannot be used<br>• **Additionally for Mycapssa:**<br>o Patient has showed clinical response to and tolerates treatment with octreotide or lanreotide therapy<br>o Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy<br>• **Additionally for Somavert:**<br>o Patient has had an inadequate response to therapy with a somatostatin analog, or has a documented medical reason why a somatostatin analog cannot be used<br>• **Additionally for Signifor LAR:**<br>o Patient has had an inadequate response to therapy with either lanreotide (Somatuline Depot) or octreotide (Sandostain, Sandostatin LAR), or has a documented medical reason why these somatostatin analogs cannot be used.<br><br><u>For Cushing's Disease (pasireotide products only)</u><br>• Patient must have had inadequate response, or medical reason why surgical treatment cannot be used<br><br>**<u>Reauthorization</u>**<br>• Medication requested is for an FDA approved indication and dose<br>• Documentation has been provided that demonstrates a clinical benefit (e.g. improvement in laboratory values, improvement or stabilization of clinical signs/symptoms, etc.)<br><br>**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.** |