Field Name	Field Description
Prior Authorization Group Description	Somatostatin Analogs and Growth Hormone Receptor Antagonists
Drugs	Octreotide (Sandostatin) Sandostatin LAR (octreotide) Lanreotide 120 mg/0.5 mL Somatuline Depot (lanreotide) 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5mL Mycapssa (octreotide) Signifor (pasireotide) Signifor LAR (pasireotide) Somavert (pegvisomant)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA) Drug Package Insert (PPI). ** 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** Initial Authorization For all FDA approved indications (including FDA-approved oncology related uses) • Medication requested is for an FDA approved indication and dose • 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

Revision/Review Date 4/2024	**monotherapy, or a medical reason was provided why monotherapy is not appropriate.**
	
	For Acromegaly
	• **Patient has had an inadequate response to, or medical reason why, surgical treatment cannot be used.**
	• **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**
	• **Additionally for Mycapssa:**
	  ○ **Patient has showed clinical response to and tolerates treatment with octreotide or lanreotide therapy**
	  ○ **Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy**
	• **Additionally for Somavert:**
	  ○ **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**
	• **Additionally for Signifor LAR:**
	  ○ **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.**
	
	For Cushing's Disease (pasireotide products only)
	• **Patient must have had inadequate response, or medical reason why surgical treatment cannot be used**
	
	Reauthorization
	• **Medication requested is for an FDA approved indication and dose**
	• **Documentation has been provided that demonstrates a clinical benefit (e.g. improvement in laboratory values, improvement or stabilization of clinical signs/symptoms, etc.)**
	
	Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.