Somatostatin Analogs

Included Products: Sandostatin (octreotide acetate), Sandostatin LAR (octreotide acetate), Signifor (pasireotide), Signifor LAR (pasireotide), Somutuline (lanreotide)

Depot products are nonformulary for outpatient benefit. PA required on medical benefit.

Created: 03/09/2017 *Revised:* 01/12/2023 *Reviewed:* 11/08/2018 *Updated:* 02/01/2023

All Diagnoses

Initial Criteria		If yes	If no
1.	Is the request prescribed by or supervised by an appropriate specialist? Acromegaly or Cushing's: endocrinologist Cancer: hematologist/oncologist	Continue to #2.	Do not approve.
2.	Is the requested product supported for the submitted indication?	Continue to #3.	Do not approve.
3.	Continue to diagnosis.		

Acromegaly

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of acromegaly confirmed by elevated IGF-1 levels?	Continue to #2.	Do not approve.
2.	Is the acromegaly moderate to severe or symptomatic?	Continue to #3.	Do not approve.
3.	Does the member have persistent disease after surgery or considered not to be a candidate for surgery?	Continue to #4.	Do not approve.
4.	Which drug is requested? a. Sandostatin LAR or octreotide, continue to #7. b. Somatuline, continue to #5. c. Signifor or Signifor LAR, continue to #6.		

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5.	Has the member tried and failed or have a contraindication to octreotide?	Continue to #7.	Do not approve and offer octreotide.
6.	Has the member tried and failed or have a contraindication to Sandostatin/Sandostatin LAR AND Somatuline?	Continue to #7.	Do not approve.
7.	Approve for 12 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member had a reduction in or has reached a target goal of GH or an age-normalized serum IGF-1 value?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Cancer			
Initial Criteria		**If yes**	**If no**
1.	Is the treatment supported for the diagnosis in the NCCN guidelines?	Continue to #3.	Continue to #2.
2.	Is the treatment being used according to the FDA indication?	Continue to #3.	Request external specialty review.
3.	Does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Prioritized List of Health Services, considering treatment of cancer with little or no benefit?	Continue to #4.	Do not approve.
4.	Approve for 12 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member reached treatment goals such as: a. Symptom control, such as reduction in diarrhea episodes or carcinoid symptoms b. Tumor control and disease stabilization	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

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Cushing's Disease

Initial Criteria		If yes	If no
1.	Is the request for the treatment of Cushing's Disease?	Continue to #2.	Do not approve..
2.	Is pituitary surgery not an option or has it not been curative?	Continue to #3.	Do not approve.
3.	Is the requested product supported for the submitted indication?	Continue to #4.	Do not approve.
4.	Approve for 12 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member had a response of a significant reduction in normalization of mean 24 hour urine-free cortisol?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		