PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Somatostatin Analogs for Acromegaly Preferred Specialty Management Policy
- Lanreotide subcutaneous injection – Cipla
- Sandostatin® LAR Depot (octreotide acetate intramuscular injection – Novartis)
- Signifor® LAR (pasireotide intramuscular injection – Recordati Rare Diseases)
- Somatuline® Depot (lanreotide subcutaneous injection – Ipsen)

REVIEW DATE: 09/21/2022

OVERVIEW

Lanreotide subcutaneous injection, Sandostatin LAR Depot, Signifor LAR, and Somatuline Depot are all somatostatin analogs indicated for the treatment of **acromegaly** in patients who have had an inadequate response to surgery, and/or radiotherapy, or in patients for whom surgery and/or radiotherapy is not an option.[1-4] Of note, Sandostatin LAR Depot is only indicated in patients who tolerated and had an effective response to initial treatment with octreotide subcutaneous injection. All of the long-acting somatostatin analogs bind to somatostatin receptors and have pharmacologic properties mimicking those of the natural hormone somatostatin. However, the affinity with which each binds to the various subtypes of somatostatin receptors varies.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Somatostatin Analogs Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the respective standard *Somatostatin Analogs Prior Authorization Policy* criteria, but has not tried a Preferred Product, a review will be offered for the Preferred Product using the respective standard *Somatostatin Analogs Prior Authorization Policy* criteria. All approvals are provided for the duration noted below.

Automation: None.

Preferred Products:	Somatuline Depot
Non-Preferred Products:	Lanreotide subcutaneous injection, Sandostatin LAR Depot, Signifor LAR

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Products	Exception Criteria
Lanreotide subcutaneous injection	**1. Acromegaly.** **A)** Approve for 1 year if the patient meets the following criteria (i and ii): **i.** Patient meets the standard *Somatostatin Analogs – Lanreotide Products Prior Authorization policy* criteria; AND **ii.** Patient meets both of the following (a and b): **a)** Patient has tried Somatuline Depot; AND **b)** Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **B)** For a patient who has not tried the Preferred Product (Somatuline Depot) for acromegaly, offer to review using the standard *Somatostatin Analogs – Lanreotide Products Prior Authorization Policy*. **2. Other Conditions.** Approve for 1 year if the patient meets the standard *Somatostatin Analogs – Lanreotide Products Prior Authorization Policy* criteria.
Sandostatin LAR Depot	**1. Acromegaly.** **A)** Approve for 1 year if the patient meets the following criteria (i and ii): **i.** Patient meets the standard *Somatostatin Analogs – Sandostatin LAR Depot Prior Authorization Policy* criteria; AND **ii.** Patient has tried Somatuline Depot. **B)** For a patient who has not tried the preferred product (Somatuline Depot) for acromegaly, offer to review using the standard *Somatostatin Analogs – Lanreotide Products Prior Authorization Policy*. **2. Other Conditions.** Approve for 1 year if the patient meets the standard *Somatostatin Analogs – Sandostatin LAR Depot Prior Authorization Policy* criteria.
Signifor LAR	**1. Acromegaly.** **A)** Approve for 1 year if the patient meets the following criteria (i and ii): **i.** Patient meets the standard *Somatostatin Analogs – Signifor LAR Prior Authorization policy* criteria; AND **ii.** Patient has tried Somatuline Depot. **B)** For a patient who has not tried the Preferred Product (Somatuline Depot) for acromegaly, offer to review using the standard *Somatostatin Analogs – Lanreotide Products Prior Authorization Policy*. **2. Other Conditions.** Approve for 1 year if the patient meets the standard *Somatostatin Analogs – Signifor LAR Prior Authorization Policy* criteria.

REFERENCES

1. Somatuline® Depot subcutaneous injection [prescribing information]. Basking Ridge, NJ: Ipsen; April 2022.
2. Sandostatin® LAR Depot intramuscular injection [prescribing information]. East Hanover, NJ: Novartis; March 2021.
3. Signifor® LAR intramuscular injection [prescribing information]. Lebanon, NJ: Recordati Rare Diseases; July 2021.
4. Lanreotide subcutaneous injection [prescribing information]. Warren, NJ: Cipla; December 2021.