PHARMACY POLICY STATEMENT **Ohio Medicaid**	
DRUG NAME	Injectable somatostatin analogs (First generation): Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot (lanreotide)
BILLING CODE	J2354/ J2353/ J1930
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	**Click Here**

Somatuline depot (lanreotide) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit; Sandostatin (octreotide) and Sandostatin LAR (octreotide) are **preferred** products and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACROMEGALY

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has diagnosis of uncontrolled acromegaly confirmed by insulin-like growth factor (IGF-1) elevation above normal level (lab report required); AND
4. Member had an inadequate response to surgery or radiation, or member is ineligible for these treatments (documentation required); AND
5. If IGF-1 elevation is 1.5x upper limit of normal or less, member must have a trial of, or contraindication or intolerance to cabergoline.[3]
6. For Somatuline Depot only: Must have a trial and failure of Sandostatin LAR.
7. **Dosage allowed:**
   Octreotide: Initial 50mcg subQ/IV 3 times daily, titrate as indicated, usual maintenance dose 100mcg 3 times daily, max 500mcg 3 times daily. NOTE: Doses in excess of 300mcg per day seldom confer additional benefit.
   Sandostatin LAR: Start at 20mg IM every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 40mg every 4 weeks.
   Somatuline depot: Start at 90mg subQ every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 120mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes/lab report must show normalized or improved (decreased) IGF-1.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

CARCINOID SYNDROME

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an oncologist or gastroenterologist; AND
3. Member has a neuroendocrine tumor, including carcinoid tumor or vasoactive intestinal peptide tumor (VIPoma); AND
4. Member is experiencing flushing and/or diarrhea symptoms associated with carcinoid syndrome (or VIPoma syndrome), not attributed to another cause.
5. For Somatuline Depot only: Must have a trial and failure of Sandostatin LAR.
6. For Bynfezia only:
   a) Baseline thyroid function testing is required; AND
   b) Trial and failure of short acting octreotide (generic Sandostatin).
7. **Dosage allowed:**
   Octreotide: 100mcg-750mcg per day subQ/IV in divided doses.
   Sandostatin LAR: 10mg to 30mg IM every 4 weeks.
   Somatuline depot: 120mg subQ every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. For short-acting product (octreotide): Chart notes must document symptomatic improvement of flushing and/or diarrhea episodes.
2. For long-acting products (Sandostatin LAR, Somatuline Depot): Chart notes must document reduced frequency of short-acting somatostatin analog rescue therapy for symptom control.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

GASTROENTEROPANCREATIC NEUROENDOCRINE TUMORS (GEP-NETs)

Any request for **cancer** must be submitted through NantHealth/Eviti portal.

CareSource considers Sandostatin (octreotide), Sandostatin LAR (octreotide), and Somatuline depot (lanreotide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/03/2020	New policy for injectable somatostatin analogs created.
10/06/2022	Removed Bynfezia due to OH single PBM.

References:

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9. Cook R, Hendifar AE. Evidence-Based Policy in Practice: Management of Carcinoid Syndrome Diarrhea. P T. 2019;44(7):424-427.
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