curative

Somatostatin Analogs Prior Authorization

Drug(s) Applied:	**Octreotide acetate** (short-acting)**, lanreotide acetate** (long-acting)

Criteria:
Drug(s) Applied will be approved when the requested medication is being used for a compendia-supported indication and all of the following criteria are met:

I. Initial Therapy Criteria

A. Acromegaly as indicated by chart notes within past 120 days

1. Requested drug is lanreotide acetate **and**
2. ONE of the following:
   a) Patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by growth hormone and serum IGF-1 that are above the reference ranges
   b) Patient is not a candidate for surgical resection **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., endocrinology)

Approval Duration: 3 months

B. Metastatic carcinoid tumors as indicated by chart notes within past 120 days

1. Patient has flushing and/or diarrhea associated with metastatic carcinoid tumors **and**
2. Patient's age is within FDA labeling for the requested indication or there is support for using the requested agent for the patient's age for the requested indication **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

Approval Duration: 6 months

C. Vasoactive Intestinal Peptide secreting tumors (VIPomas)as indicated by chart notes within past 120 days

1. Patient has profuse watery diarrhea associated with VIP secreting tumors **and**
2. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

Approval Duration: 6 months

D. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) as indicated by chart notes within past 120 days

1. Tumors are well differentiated or moderately differentiated **and**
2. Tumors are unresectable locally advanced or patient has metastatic disease **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

Approval Duration: 6 months

E. Another compendia-supported indication as indicated by chart notes within past 120 days

1. Requested drug is FDA-approved or NCCN-supported with category 1 or 2A for the requested indication **and**
2. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

Approval Duration: 6 months

II. Continued Therapy Criteria

A. Acromegaly as indicated by chart notes within past 180 days

1. Requested agent is lanreotide acetate **and**
2. Chart notes indicate patient has been treated with the requested agent and is a continuation of therapy (starting on samples is not approvable) **and**
3. Documented clinical benefit since starting the requested agent (i.e., normalized IGF-1 and/or growth hormone levels) **and**
4. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., endocrinology)

Approval Duration: 12 months

B. All oncology indications as indicated by chart notes within past 180 days

1. Patient has been previously approved for the requested agent through the plan's Prior Authorization process or meets the initial therapy criteria above **and**
2. Documented clinical benefit since starting the requested agent (i.e., decrease in symptom severity/frequency, reduction in tumor size) **and**
3. Prescriber is a specialist or has consulted with a specialist in the area of the patient's diagnosis (e.g., oncology)

Approval Duration: 12 months

Policy Owned by: Curative PBM team