curative

Somatostatin Analogs Prior Authorization
Drug List A

Drug(s) Applied:	**Octreotide acetate** (short-acting), **lanreotide acetate, Somatuline Depot, octreotide acetate LAR** (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. ONE of the following:
     a) Patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by pre-treatment growth hormone and serum insulin-like growth factor-1 (IGF-1) levels that are above the reference ranges
     b) Patient is not a candidate for surgical resection or pituitary radiation therapy and has pre-treatment growth hormone and IGF-1 levels that are above the reference ranges **and**
  2. ONE of the following:
     a) If patient's post-surgical or post-radiation therapy IGF-1 level is <2.5 times the upper limit of normal (ULN) of the reference range, then patient has tried and had an inadequate response to a dopamine agonist (e.g., cabergoline) after an adequate trial (e.g., ≥12 weeks), or patient has a contraindication or severe intolerance to dopamine agonists
     b) If patient is not a candidate for surgical resection or pituitary radiation therapy and has a pre-treatment IGF-1 level <2.5 times the upper limit of normal (ULN) of the reference range, then patient has tried and had an inadequate response to a dopamine agonist (e.g., cabergoline) after an adequate trial (e.g., ≥12 weeks), or patient has a contraindication or severe intolerance to dopamine agonists **and**
  3. Prescriber is 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. ONE of the following:
   a) If patient has been treated with the requested agent for <3 months, patient meets the initial therapy criteria above
   b) If patient has been treated with the requested agent for ≥3 months, ONE

of the following:

(a) Patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by pre-treatment growth hormone and serum insulin-like growth factor-1 (IGF-1) levels that are above the reference ranges

(b) Patient is not a candidate for surgical resection or pituitary radiation therapy and has pre-treatment growth hormone and IGF-1 levels that are above the reference ranges **and**

2. Documented clinical benefit since starting the requested agent (i.g, normalized IGF-1 and/or growth hormone levels) **and**
3. Prescriber is 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

References:

1. Sandostatin LAR prescribing information. Novartis. December 2025.
2. Somatuline Depot prescribing information. Ipsen Biopharmaceuticals, Inc. October 2024.
3. Octreotide prescribing information. Mylan Institutional LLC. July 2024.
4. Lanreotide prescribing information. Cipla USA Inc. February 2025.
5. Mehmed S. et al. Consensus on acromegaly therapeutic outcomes: an update. Nature Reviews Endocrinology. August 2025.
6. Fleseriu M. et al. A Pituitary Society update to acromegaly management guidelines. Pituitary. Oct 2020.
7. Ogedegbe OJ, Cheema AY, Khan MA, et al. A Comprehensive Review of Four Clinical Practice Guidelines of Acromegaly. Cureus. 2022;14(9):e28722. Published 2022 Sep 3. doi:10.7759/cureus.28722
8. Daniel CP, Wagner MJ, Borne GE, et al. Acromegaly: Pathophysiological Considerations and Treatment Options Including the Evolving Role of Oral Somatostatin Analogs. Pathophysiology. 2023;30(3):377-388. doi:10.3390/pathophysiology30030029.

Policy Owned by: Curative PBM team