Clinical Policy Title:	octreotide acetate
Policy Number:	RxA.278
Drug(s) Applied:	octreotide acetate, Sandostatin® Injection, Sandostatin® LAR depot
Original Policy Date:	02/07/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Acromegaly (must meet all):

1. Diagnosis of acromegaly;
2. Epiphyseal growth plates have closed;
3. Inadequate response to surgical resection or pituitary irradiation (i.e., unable to achieve normalization of GH and/or IGF-I levels or unable to adequately control tumor mass), or member is not a candidate for such treatment.
4. Member has received Sandostatin® Injection for at least two weeks with improvement in GH or IGF-I levels, or tumor mass control.

Approval duration

All Lines of Business (except Medicare): 6 months

B. Carcinoid Tumor - Neuroendocrine Tumor of the Gastrointestinal Tract, Lung and Thymus (must meet all):

1. Diagnosis of a carcinoid tumor (most commonly arising in the lungs and bronchi, small intestine, appendix, rectum, or thymus) and one of the following (a or b):
   a. Request is for carcinoid syndrome (i.e., presence of diarrhea or flushing symptoms indicative of hormonal hypersecretion);
   b. Request is for advanced disease, with or without carcinoid syndrome;
2. If the request is for symptom management only, member has received Sandostatin® Injection for at least two weeks with improvement in diarrhea or flushing episodes.

Approval duration

All Lines of Business (except Medicare): 6 months

C. Vasoactive Intestinal Peptide Tumor and other Pancreatic Neuroendocrine Tumors (must meet all)**:**

1. Diagnosis of a pancreatic neuroendocrine tumor including but not limited to VIPoma, gastrinoma, insulinoma or glucagonoma, and one of the following (a, b, c, or d):
   a. Request is for management of symptoms indicative of hormonal hypersecretion (e.g., diarrhea);
   b. Request is for treatment of a gastrinoma with or without symptoms;
   c. For other pancreatic neuroendocrine tumors, request is for advanced disease, with or without symptoms;
   d. If request is for an insulinoma, tumor is somatostatin receptor positive on imaging;
2. If the request is for symptom management only, member has received Sandostatin® Injection for at

least two weeks with improvement in diarrhea or flushing episodes.

Approval duration

All Lines of Business (except Medicare): 6 months

D. Thymoma and Thymic Carcinoma (off-label) (must meet all):

1. Diagnosis of thymoma or thymic carcinoma;
2. Prescribed as second-line therapy (first-line therapies include CAP [cisplatin, doxorubicin, cyclophosphamide], ADOC [cisplatin, doxorubicin, vincristine, cyclophosphamide], PE [cisplatin, etoposide], VIP [etoposide, ifosfamide, cisplatin], carboplatin/paclitaxel.

Approval duration

All Lines of Business (except Medicare): 6 months

E. Pheochromocytoma/Paraganglioma (off-label) (must meet all):

1. Diagnosis of Pheochromocytoma or Paraganglioma;
2. Request is for one of the followings (a or b):
   a. Symptom control of locally unresectable disease if somatostatin receptor positive imaging and symptomatic
   b. Symptom control of distant metastases that are secreting tumors as a continuation of medical therapy.

Approval duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. All Indication in Section I (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Neuroendodrine and adrenal tumors. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed August 28, 2024.
2. National Comprehensive Cancer Network. Central nervous system cancers. Version 2.2024. National Comprehensive Cancer Network Guidelines. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf. Accessed August 28, 2024.
3. National Comprehensive Cancer Network. Thymomas and thymic carcinomas. Version 1.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) applied was updated. 3. Line of Business Policy Applies to was updated to "All lines of business". 4. Initial and Continued approval duration was	08/28/2020	09/14/2020

updated to specify Medicaid, Commercial & HIM approval duration. 5. Continued therapy criteria II.A.1, II.B.1, II.C.1, II.D.1 & II.E.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance…". 6. Initial and continuation criteria was updated to include Pheochromocytoma/Paraganglioma. 7. References were updated.		
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Continued therapy criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance.." 3. References were reviewed and updated.	04/09/2021	06/10/2021
Policy was reviewed: 1. Initial Approval Criteria, I.A.2: Updated to include new prescriber criteria Prescribed by or in consultation with an endocrinologist. 2. Initial Approval Criteria, I.D: Updated to remove approval criteria for Meningioma (off-label). 3. Initial Approval Criteria, I.E.3: Updated to include new diagnostic criteria Request is for locally unresectable disease or distant metastases. 4. Continued Therapy Approval Criteria, II.D: Updated to remove approval criteria for Meningioma (off-label). 5. References were reviewed and updated.	01/10/2022	04/18/2022
Policy was reviewed: 1. References were reviewed and updated.	01/06/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Added generic octreotide acetate to Drug(s) Applied. 2. Removed age restrictions. 3. Removed prescriber restrictions. 4. Removed dose restrictions. 5. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 6. Reauthorization criteria for all the diagnosis merged under "All Indications in Section I" 7. Removed reauthorization requirement for positive response to therapy. 8. Updated approval duration verbiage.	8/28/2024	9/13/2024

9. References were reviewed and updated.		