Clinical Policy Title:	pasireotide
Policy Number:	RxA.478
Drug(s) Applied:	Signifor®, Signifor® LAR
Original Policy Date:	03/06/2020
Last Review Date:	08/28/2024
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. Request is for Signifor® LAR;
3. Inadequate response to surgical resection or pituitary irradiation, or member is not a candidate for such treatment.

Approval duration

All Lines of Business (except Medicare): 6 months

B. Cushing's Disease (must meet all)**:**

1. Diagnosis of Cushing's disease;
2. Member meets one of the following (a or b):
   a. Pituitary surgery was not curative;
   b. Member is not eligible for pituitary surgery.

Approval duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

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

1. Member is currently receiving or has been treated with this medication within the past 120 days, excluding manufacturer samples;
2. If the diagnosis is acromegaly, the request is for Signifor LAR.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Katznelson L, Atkinson JLD, Cook DM, Ezzat SZ, Hamrahian AH, Miller KK. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. Endocrine Practice. 2011;17(Suppl 4). Available at: https://endosuem.org.uy/wp-content/uploads/2016/07/Guias-AACE-2011.pdf. Accessed August 28, 2024.
2. Tritos NA, Biller BMK. Current management of Cushing's disease. J Intern Med. 2019 Nov;286(5):526-541. doi: 10.1111/joim.12975. Epub 2019 Oct 4. PMID: 31512305. Available at: https://pubmed.ncbi.nlm.nih.gov/31512305/. Accessed August 28, 2024.

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was established	01/2020	03/06/2020
Policy was reviewed: 1. Approval duration for commercial plan was updated: - Initial approval: 6 months. - Continued therapy approval: 12 months. 2. Rephrased Continued Therapy criteria II.A.1. and II.B.1 to “currently receiving medication that has been authorized by RxAdvance benefit…”. 3. References were reviewed and updated.	05/2020	05/21/2020
Policy was reviewed: 1. Policy title table was updated. 2. Continued therapy approval criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 3. References were updated.	02/19/2021	03/09/2021
Policy was reviewed: 1. Continued Therapy Approval Criteria II.A.1 and II.B.1 were rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	12/09/2021	01/17/2022
Policy was reviewed: 1. References were reviewed and updated.	10/18/2022	01/17/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed. 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with the new verbiage containing 120 days lookback period. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage. 7. Reauthorization criteria for all the diagnosis merged under “All Indications in Section I”. 8. References were reviewed and updated.	08/28/2024	09/13/2024

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