Clinical Policy: Octreotide Acetate (Sandostatin, Sandostatin LAR Depot)

Reference Number: CP.PHAR.40
Effective Date: 03.01.10
Last Review Date: 02.18
Line of Business: Commercial, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Octreotide acetate (Sandostatin® Injection, Sandostatin® LAR Depot) is a somatostatin analogue.

FDA Approved Indication(s)

Sandostatin Injection is indicated:

- To reduce blood levels of growth hormone (GH) and insulin-like growth factor (IGF-I (somatomedin C) in acromegaly patients who have had inadequate response or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses;
- For the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease;
- For the treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors (VIPomas).

Sandostatin LAR Depot is indicated:

- For treatment in patients who have responded to and tolerated Sandostatin Injection subcutaneous injection for:
  - Acromegaly;
  - Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors;
  - Profuse watery diarrhea associated with VIP-secreting tumors.

Limitation(s) of use:
In patients with carcinoid syndrome and VIPomas, the effect of Sandostatin Injection and Sandostatin LAR Depot on tumor size, rate of growth and development of metastases, has not been determined.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Sandostatin Injection and Sandostatin LAR Depot are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Acromegaly (must meet all):

1. Diagnosis of acromegaly;
2. Age ≥ 18 years or, if younger, 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. Request is for one or both of the following formulations (a and b):
   a. Sandostatin Injection:
      i. Dose does not exceed 1,500 mcg/day in divided doses;
   b. Sandostatin LAR Depot (i and ii):
      i. Dose does not exceed 40 mg every 4 weeks.
      ii. Member has received Sandostatin Injection for at least two weeks with improvement in GH or IGF-I levels, or tumor mass control.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

B. Carcinoid Tumors (neuroendocrine tumors associated with hormonal hypersecretion) (must meet all):
1. Diagnosis of diarrhea or flushing episodes associated with a metastatic carcinoid tumor;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for one or both of the following formulations (a and b):
   a. Sandostatin Injection:
      i. Dose does not exceed 1500 mcg/day in divided doses;
   b. Sandostatin LAR Depot (i and ii):
      i. Dose does not to exceed 30 mg every 4 weeks;
      ii. Member has received Sandostatin Injection for at least two weeks with improvement in diarrhea or flushing episodes.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

C. Vasoactive Intestinal Peptide Tumors (neuroendocrine tumors associated with VIP secretion) (must meet all):
1. Diagnosis of diarrhea associated with a VIPoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request is for one or both of the following:
   a. Sandostatin injection:
      i. Dose does not exceed 750 mcg/day in divided doses;
   b. Sandostatin LAR Depot (i and ii):
      i. Dose does not exceed 30 mg every 4 weeks;
      ii. Member has received Sandostatin Injection for at least two weeks with improvement in diarrhea prior to request for Sandostatin LAR Depot.

Approval duration:
Medicaid - 6 months

Commercial – 6months

D. Meningioma (off-label) (must meet all):
1. Diagnosis of meningioma (central nervous system cancer);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Treatment for surgically inaccessible recurrent or progressive meningiomas when radiation is not possible;
5. Dose for Sandostatin Injection and/or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence)*.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

E. Thymoma and Thymic Carcinoma (off-label) (must meet all):
1. Diagnosis of thymoma or thymic carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Second-line therapy (first-line therapies include CAP [cisplatin, doxorubicin, cyclophosphamide], ADOC [cisplatin, doxorubicin, vincristine, cyclophosphamide], PE [cisplatin, etoposide], VIP [etoposide, ifosfamide, cisplatin], carboplatin/placlitaxel;
5. Dose for Sandostatin Injection and/or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence)*.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

F. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Acromegaly (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy (e.g., improvement in GH or IGF-1 serum concentrations, or in tumor mass control, since initiation of therapy);
3. If request is for a dose increase, request is for one or both of the following (a and b):
   a. Sandostatin Injection: New dose does not exceed 1,500 mcg/day in divided doses;
   b. Sandostatin LAR Depot: New dose does not exceed 40 mg every 4 weeks.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

B. Carcinoid Tumors (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sandostatin and/or Sandostatin LAR for carcinoid tumor and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
5. If request is for a dose increase, request is for one or both of the following (a and b):
   a. Sandostatin Injection: New dose does not exceed 1500 mcg/day in divided doses;
   b. Sandostatin LAR Depot: New dose does not to exceed 30 mg every 4 weeks.

Approval duration:
Medicaid - 6 months
Commercial – 6 months

C. Vasoactive Intestinal Peptide Tumors (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sandostatin and/or Sandostatin LAR for a VIPoma and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request is for one or both of the following:
   a. Sandostatin injection: New dose does not exceed 750 mcg/day in divided doses;
   b. Sandostatin LAR Depot: New dose does not exceed 30 mg every 4 weeks;

Approval duration:
Medicaid - 6 months
Commercial – 6 months

D. Meningioma (off-label) (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose for Sandostatin Injection and/or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence).*

Approval duration:
Medicaid - 6 months
Commercial – 6 months

E. Thymoma and Thymic Carcinoma (off-label) (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;

3. If request is for a dose increase, new dose for Sandostatin Injection and/or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence).*

Approval duration:
Medicaid - 6 months
Commercial – 6 months

F. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
GH: growth hormone
IGF-1: insulin growth factor 1 (somatomedin C)
VIPomas: vasoactive intestinal peptide tumors

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: General Information
GH excess occurring in growing children/adolescents before epiphyseal growth plate closure (known as pituitary gigantism) is not included in the present policy given unique etiologic and management considerations.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Octreotide acetate (Sandostatin® Injection) (SC or IV)	Acromegaly	Up to 1500 mcg in 2 or more divided doses	1500 mcg/day
	Carinoid tumors	Up to 1500 mcg in 2 or more divided doses	1500 mcg/day
	VIPomas	Up to 750 mcg in 2 or more divided doses	750 mcg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
Octreotide acetate (Sandostatin® LAR Depot) (IM)	Acromegaly	20-40 mg every 4 weeks	40 mg/4 weeks
	Carcinoid tumors	20-30 mg every 4 weeks	30 mg/4 weeks
	VIPomas	20-30 mg every 4 weeks	30 mg/4 weeks

VI. Product Availability

Drug Name	Availability
Octreotide acetate (Sandostatin® Injection)	Single-use ampule: 50 mcg/mL, 100 mcg/mL, 500 mcg/mL Multi-dose vial: 200 mcg/mL, 1000 mcg/mL
Octreotide acetate (Sandostatin® LAR Depot)	Single-use kit (vial): 10 mg, 20 mg, 30 mg

VII. References

1. Sandostatin Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2012. Available at http://www.pharma.us.novartis.com/product/pi/pdf/sandostatin_inj.pdf. Accessed November 2017.
2. Sandostatin LAR Depot prescribing information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2016. Available at http://www.pharma.us.novartis.com/product/pi/pdf/sandostatin_lar.pdf. Accessed November 2017.
3. Melmed S, Colao A, Barkan A, et al. Guidelines for acromegaly management: an update. J Clin Endocrinol Metab. May 2009; 94(5): 1509-1517.
4. Neuroendodrine tumors (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed November 2017.
5. Central nervous system cancers (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed November 2017.
6. Thymomas and thymic carcinomas (Version 1.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed November 2017.
7. Octreotide acetate. In: National Comprehensive Cancer Network Compendium. Available at nccn.org. Accessed November 2017.
8. Octreotide acetate (LAR). In: National Comprehensive Cancer Network Compendium. Available at nccn.org. Accessed November 2017.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg

HCPCS Codes	Description
J2354	Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added limitations of use to Description Removed prospective question regarding stopping therapy to Figure 1	05.01.14	06.14
Updated background to include Carcinoid tumors and VIPoma and safety warnings. Updated Appendix E and references.	02.01.15	05.15
For all three indications: Age added per PI; documentation requests removed; dosing parameters added per PI; initial approval period increased to 3 months. Acromegaly: Bromocriptine requirement removed; cabergoline; monitoring parameters edited to include IGF-1, GH and tumor mass; removed requirement that member have clinical evidence of acromegaly per App B. Carcinoid tumors: Clarified that carcinoid tumors are now known as neuroendocrine tumors of the GI tract, lung, and thymus; removed requirement that member be experiencing carcinoid syndrome as outlined in App D; removed question about whether member is a candidate for surgery as surgery can be used with octreotide to cure or control. VIPomas: Removed the requirement that patients try other medications for diarrhea; as with carcinoid tumors, questions about surgery are removed.	03.01.16	05.16
The following criteria in section A "acromegaly" is removed: "If member has received pituitary irradiation Sandostatin LAR Depot will be withdrawn yearly for approximately 8 weeks to assess disease activity (*if GH or IGF-1 levels increase and signs and symptoms recur Sandostatin LAR Depot therapy may be resumed*)." Hypersensitivity removed as a contraindication. Acromegaly continuation criteria edited to allow 12 months of therapy before evidence of efficacy; renewal approval durations throughout policy are lengthened to 12 months. NCCN compendial uses are added for carcinoids and VIPomas in section D.	03.17	03.17
1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business -Specialist added for oncology indications	11.30.17	02.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
-Requests for non-oncology off-label indications and any oncology off-label indications not outlined above are directed to the off-label use policies referenced in Section I.F. - Positive therapeutic response examples (diarrhea, flushing, disease progression, unacceptable toxicity) are removed as they are not amenable to objective measurement. -References updated. Updated approval duration to 6 months.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.