BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

OCTREOTIDE ACETATE products, oral and injection:
MYCAPSSA® (octreotide acetate) oral
Octreotide acetate injection solution
Octreotide acetate injection suspension
SANDOSTATIN® (octreotide acetate) injection solution
SANDOSTATIN LAR DEPOT® (octreotide acetate) injection suspension
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

MYCAPSSA® (octreotide acetate) oral

➢ **Criteria for initial therapy:** Mycapssa (octreotide acetate) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

PHARMACY COVERAGE GUIDELINE

OCTREOTIDE ACETATE products, oral and injection

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Endocrinologist

2. Individual is 18 years of age or older

3. Individual has a confirmed diagnosis of **acromegaly** who is tolerating long-acting somatostatin analog injection therapy and is biochemically controlled

4. Individual is using stable dose (for at least 6 months) **ONE** the following long-acting somatostatin analog injection therapy:
    a. Octreotide acetate long acting injection
    b. Somatuline Depot (lanreotide) injection

5. Evidence of biochemical control is documented by insulin-like growth factor 1 (IGF-1) level less than or equal to the upper limit of normal for the patient's age and gender while on a long-acting somatostatin analog injection therapy

6. Provider must submit clinical justification why the individual is unable to be kept on current effective, stable and tolerating long-acting octreotide or lanreotide injection therapy

7. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Mycapssa (octreotide) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met **(samples are not considered for continuation of therapy):**

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Endocrinologist

2. Individual has documentation of positive clinical response to therapy defined as **ALL** of the following:
    a. No evidence of disease progression
    b. Achieved and maintains normalization of growth hormone and IGF-I levels for age and gender (must use the same laboratory assay that was used at baseline measurement, laboratory reference range must be provided)

3. Individual has been adherent with the medication and the requested dose is **NOT** greater than 80 mg daily

4. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. Individual has not developed any significant adverse drug effects that may exclude continued use such as:

a. Acute cholecystitis
b. Acute intestinal obstruction
c. Ascending cholangitis
d. Biliary obstruction
e. Cholelithiasis
f. Cholestatic hepatitis
g. Pancreatitis

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

Octreotide acetate injection solution, generic
Octreotide acetate injection suspension, generic
SANDOSTATIN® (octreotide acetate) injection solution
SANDOSTATIN LAR DEPOT® (octreotide acetate) injection suspension

- **Criteria for initial therapy:** Octreotide acetate injection solution, Sandostatin (octreotide acetate) injection solution, Sandostatin LAR Depot (octreotide acetate) injection suspension, or octreotide acetate injection suspension is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Endocrinologist, Gastroenterologist, or Oncologist depending upon the diagnosis

2. Individual is 18 years of age or older

3. Individual has a confirmed diagnosis of **ONE** of the following:
   a. Acromegaly in an individual who has had an inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine **or** cabergoline at maximally tolerated doses

   b. Metastatic carcinoid tumor to suppress or inhibit the severe diarrhea/flushing episodes associated with the disease

   c. Vasoactive Intestinal Peptide (VIP) secreting tumor and has profuse watery diarrhea associated with VIP-secreting tumors

   d. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus

of 1 and 2A

4. Individual has completed a baseline thyroid function tests (TSH, total and/or free T4) before initiation of treatment and will have continued monitoring as clinically appropriate

5. **For brand Sandostatin (octreotide acetate) injection solution**: Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for **generic octreotide acetate injection solution** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

6. **For brand Sandostatin LAR Depot (octreotide acetate) injection suspension:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for **generic octreotide acetate injection suspension** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Octreotide acetate injection solution, Sandostatin (octreotide acetate) injection, Sandostatin LAR Depot (octreotide acetate) injection suspension, or octreotide acetate injection suspension is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy):**

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Endocrinologist, Gastroenterologist, or Oncologist depending upon the diagnosis

2. Individual has documentation of positive clinical response to therapy defined as the following:
   a. **For acromegaly**:
      i. No evidence of disease progression
      ii. Achieved and maintains normalization of growth hormone and IGF-I levels for age and gender **or** GH levels are less than 1 ng/mL or 1 mcg/L [**Note**: 1 nanogram / milliliter = 1 microgram / liter]
   b. **For Carcinoid tumor**:
      i. No evidence of disease progression
      ii. Achieved and maintains an improvement in severe diarrhea and flushing episodes associated with the disease
      iii. Urinary 5-hydroxyindole acetic acid (5-HIAA) levels are reduced or have normalized
   c. **For VIP-secreting tumor**:
      i. No evidence of disease progression
      ii. Achieved and maintains an improvement in the number of profuse watery diarrhea episodes
      iii. Plasma VIP levels are reduced or have normalized

3. Individual has been adherent with the medication

4. **For brand Sandostatin (octreotide acetate) injection solution**: Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for **generic octreotide acetate injection solution** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. **For brand Sandostatin LAR Depot (octreotide acetate) injection suspension:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for **generic octreotide acetate injection suspension** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

6. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
    a. Acute cholecystitis
    b. Acute intestinal obstruction
    c. Ascending cholangitis
    d. Biliary obstruction
    e. Cholelithiasis
    f. Cholestatic hepatitis
    g. Pancreatitis

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

Description:

Mycapssa (octreotide acetate) is a somatostatin analog indicated for long-term maintenance treatment in acromegaly. Mycapssa contains octreotide acetate in a delayed release, enteric coated, capsule.

Octreotide acetate injection is indicated to reduce blood levels of growth hormone (GH) and insulin-like growth factor 1 (IGF-I, also known as somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses. The goal is to achieve normalization of growth hormone (less than 5 ng/mL) and IGF-1 levels (less than 1.9 unit/mL in males and less than 2.2 unit/mL in females). Improvement in clinical signs and symptoms, or reduction in tumor size or rate of growth, were not shown in clinical trials performed with octreotide acetate injection; these trials were not optimally designed to detect such effects.

Octreotide acetate injection is also indicated 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. Octreotide acetate injection studies were not designed to show an effect on the size, rate of growth or development of metastases.

Octreotide acetate injection is also indicated for the treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors. Octreotide acetate injection studies were not designed to show an effect on the size, rate of growth or development of metastases.

PHARMACY COVERAGE GUIDELINE

OCTREOTIDE ACETATE products, oral and injection

Octreotide acetate exerts pharmacologic actions like the natural hormone somatostatin but is a more potent inhibitor of GH, glucagon, and insulin than somatostatin. Like somatostatin, it suppresses luteinizing hormone (LH) response to gonadotropin-releasing hormone (GnRH), decreases splanchnic blood flow, and inhibits release of serotonin, gastrin, VIP, secretin, motilin, and pancreatic polypeptide.

Acromegaly is a disease characterized by excessive release of GH. Increased levels of GH stimulate an increase in hepatic production of IGF-1. Excess IGF-1 causes increased growth of bones and soft-tissues while excess GH can cause other conditions such as diabetes mellitus, hypertension, and an increase in cardiovascular risk. Both serum GH concentrations and IGF-1 concentrations are increased in virtually all patients with acromegaly.

The goals of therapy in patients with acromegaly are to lower the serum IGF-1 concentration to within the normal range for the patient's age and gender and to lower the serum GH concentration to < 1 mcg/L. The Endocrine Society guidelines suggest that an age-normalized serum IGF-1 and a random GH < 1 mcg/L should both be therapeutic goals as they correlate with control of acromegaly.

First-generation long-acting somatostatin injectable analog (e.g., lanreotide, octreotide) are considered first-line therapy in patients with persistent disease despite surgical resection or in whom surgery is not appropriate.

Alternative agents are suggested for patients with mild disease postoperatively.

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Resources:

Mycapssa (octreotide acetate) delayed release capsule product information, revised by Amryt Pharmaceuticals Designated Activity Company 03-2022. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Octreotide acetate injection solution product information, revised by Hainan Shuangcheng Pharmaceuticals Co., Ltd, Inc 02-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Sandostatin (octreotide acetate) injection solution product information, revised by Novartis Pharmaceuticals Corporation 07-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Sandostatin LAR Depot (octreotide acetate) injection suspension product information, revised by Novartis Pharmaceuticals Corporation 07-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Octreotide acetate injection suspension product information, revised by Teva Pharmaceuticals Inc. 07-2024. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed June 27, 2025.

Melmed S, Katznelson L. Diagnosis of acromegaly. In: UpToDate, Snyder PJ, Martin KA (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated May 28, 2024. Accessed September 04, 2025.

Melmed S, Katznelson L. Treatment of acromegaly. In: UpToDate, Snyder PJ, Martin KA (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated April 28, 2023. Accessed September 04, 2025.

Strosberg JS. Diagnosis of carcinoid syndrome and tumor localization. In: UpToDate, Tanabe KK, Whitcomb DC, Morse B, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated March 19, 2025. Accessed September 04, 2025.

Strosberg JS. Treatment of carcinoid syndrome. In: UpToDate, Tanabe KK, Whitcomb DC, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated August 29, 2024. Accessed September 04, 2025.

Bergsland E. Clinical presentation, diagnosis, and management of VIPoma. In: UpToDate, Tanabe KK, Whitcomb DC, Shah SM (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through August 2025. Topic last updated August 04, 2025. Accessed September 04, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Neuroendocrine and Adrenal Tumors Version 2.2025 – Updated May 28, 2025. Available at https://www.nccn.org. Accessed September 04, 2025.

Fleseriu M, Biller, BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. Pituitary. 2021; 24:1-13. Accessed September 04, 2024. Re-evaluated September 04, 2025.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.