

Updated: 04/2023 PARP Approved: 05/2023

Prior Authorization Criteria Sandostatin LAR Depot (octreotide acetate)

All requests for Sandostatin LAR Depot (octreotide acetate) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- The member is 18 years of age or older
- Prescribed by or in consultation with an Endocrinologist, Oncologist, or Hematologist
- Previous treatment with octreotide (Sandostatin) immediate release was effective and tolerated
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a <u>diagnosis</u> of **acromegaly** and the following criteria is met:

- Must have an inadequate response to surgery or radiation therapy, unless surgery and/or radiotherapy is not an option
- Documentation of **both** of the following:
 - o Elevated serum IGF-1 level for member's gender and age range. Laboratory reference range must be provided.
 - Elevated growth hormone (GH) level defined as a GH level ≥1ng/mL following an oral glucose tolerance test (OGTT)
- Initial Duration of Approval: 6 months
- Reauthorization criteria
 - o Documentation of ALL of the following:
 - Chart documentation of clinical benefit and tolerance
 - IGF-1 level has decreased or stabilized since initiation of therapy
 - GH level has decreased or stabilized since initiation of therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a <u>diagnosis</u> of **metastatic carcinoid tumors** and the following criteria is met:

- The member has severe diarrhea and/or flushing episodes
- **Initial Duration of Approval:** 6 months
- Reauthorization criteria
 - Member is experiencing a decrease in severity and occurrence of diarrhea and/or flushing
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a <u>diagnosis</u> of **vasoactive intestinal peptide tumors** (**VIPomas**) and the following criteria is met:

- The member has profuse watery diarrhea associated with VIP-secreting tumors
- **Initial Duration of Approval:** 6 months



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- Reauthorization criteria
 - Member is experiencing a decrease in severity and occurrence of diarrhea and/or flushing
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of **gastroenteropancreatic neuroendocrine tumors** (GEP-NETs) and the following criteria is met:

- Must have locoregionally advanced and/or metastatic disease
- Initial Duration of Approval: 6 months
- Reauthorization criteria
 - o Member continues to meet initial criteria
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



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SANDOSTATIN LAR DEPOT (OCTREOTIDE ACETATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation

as applical	ble to Highmark Wholecare	Pharmacy Servi	ices. FA	X: (888) 245-	-2049	
If needed, you may call to speak to						
	PROVIDER 1	INFORMATIO	ON			
Requesting Provider:			Provider NPI:			
Provider Specialty:			Office Contact:			
State license #:			Office NPI:			
Office Address:			Office Phone:			
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	MEMBER I	NFORMATIO	N			
Member Name:	DOB:	_				
Member ID:	Member we	Member weight: Height:				
REQUESTED DRUG INFORMATION						
Medication:	Strength:	Strength:				
Directions:	Quantity:	•				
Is the member currently receiving re			Date Medication Initiated:			
		nformation				
This medication will be billed: a	<u> </u>	ically, JCODE:				
Place of Service: Hospital			Other			
Place of Service Information						
Name:		NI	NPI:			
Address:		Ph	ione:			
MEDICAL HISTORY (Complete for ALL requests)						
Diagnosis: ICD Code:						
Was octreotide (Sandostatin) imi	mediate release effective a		☐ Ye	es No		
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