BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 11/18/2021
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OCTREOTIDE ACETATE products, oral and injection:
BYNFEZIA PEN (octreotide acetate) injection
MYCAPSSA® (octreotide acetate) oral
Octreotide Acetate injection
SANDOSTATIN® (octreotide acetate) injection
SANDOSTATIN LAR DEPOT® (octreotide) injection

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

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Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

MYCAPPSA® (octreotide acetate) oral

Criteria:

- **Criteria for initial therapy:** Mycapssa (octreotide acetate) 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
  2. Individual is 18 years of age or older
  3. A confirmed diagnosis of acromegaly in an individual who has responded to and has tolerated somatostatin analog injection therapy
  4. Individual is biochemically controlled and has tolerated a stable dose of somatostatin analog injection therapy (for at least 6 months) using **ONE** the following:
     a. Sandostatin LAR (octreotide acetate) injection
     b. Somatuline Depot (lanreotide) injection
     c. Bynfezia Pen (octreotide acetate)
  5. There is evidence of biochemical control through documentation of 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 somatostatin analog injection therapy
  6. There are no significant interacting drugs

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Mycapssa (octreotide) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Endocrinologist
  2. Individual's condition responded while on therapy
     a. Response is defined as:
        i. No evidence of disease progression
        ii. Achieved and maintains

1. Using the same laboratory assay that was used at baseline measurement (laboratory reference range must be provided):
    a. Achieved and maintains normalization of growth hormone and IGF-I levels for age and gender

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

4. Individual has not developed any significant adverse drug effects that may exclude continued use
    a. Significant adverse effect such as:
        i. Acute cholecystitis
        ii. Acute intestinal obstruction
        iii. Ascending cholangitis
        iv. Biliary obstruction
        v. Cholelithiasis
        vi. Cholestatic hepatitis
        vii. Pancreatitis

5. There are no significant interacting drugs

    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 a Non-cancer Medications**

    2. **Off-Label Use of a Cancer Medication for the Treatment of Cancer without a Specific Coverage Guideline**

BYNFEZIA PEN™ (octreotide acetate) injection
Octreotide Acetate injection, generic
SANDOSTATIN® (octreotide acetate) injection
SANDOSTATIN LAR DEPOT® (octreotide acetate) injection

Criteria:

- **Criteria for initial therapy:** Bynfezia Pen (octreotide acetate), Octreotide acetate, Sandostatin (octreotide acetate), or Sandostatin LAR Depot (octreotide acetate) 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

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2. Individual is 18 years of age or older

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

    b. Severe diarrhea/flushing episodes associated with metastatic Carcinoid tumors

    c. Profuse watery diarrhea associated with Vasoactive Intestinal Peptide (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. **ALL** of the following **baseline tests** have been completed before initiation of treatment with continued monitoring as clinically appropriate:
    a. Thyroid function tests (TSH, total and/or free T4)

5. **ONE** of the following:
    a. **For Bynfezia Pen (octreotide acetate)**:
        i. Documented failure, contraindication per FDA label, intolerance, or not a candidate for generic octreotide acetate

    b. **For Sandostatin (octreotide acetate)**:
        i. Documented failure, contraindication per FDA label, intolerance, or not a candidate for generic octreotide acetate

    c. **For Sandostatin LAR Depot (octreotide acetate)**:
        i. There is evidence of biochemical control through documentation of 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 somatostatin analog injection therapy

6. There are no significant interacting drugs

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Bynfezia Pen (octreotide acetate), Octreotide acetate, Sandostatin (octreotide acetate), or Sandostatin LAR Depot (octreotide acetate) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

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's condition has responded while on therapy
    a. Response is defined as:
        i. **For acromegaly**:
            1. No evidence of disease progression
            2. Achieved and maintains normalization of growth hormone and IGF-I levels for age and gender or GH levels are less than 5 ng/mL
        ii. **For Carcinoid tumor**:
            1. No evidence of disease progression
            2. Achieved and maintains an improvement in severe diarrhea and flushing episodes associated with the disease
            3. Urinary 5-hydroxyindole acetic acid (5-HIAA), plasma serotonin, and plasma substance-P levels are reduced or have normalized
        iii. **For VIP-secreting tumor**:
            1. No evidence of disease progression
            2. Achieved and maintains an improvement in the number of profuse watery diarrhea episodes
            3. Plasma VIP levels are reduced or have normalized

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
    a. Significant adverse effect such as:
        i. Acute cholecystitis
        ii. Acute intestinal obstruction
        iii. Ascending cholangitis
        iv. Biliary obstruction
        v. Cholelithiasis
        vi. Cholestatic hepatitis
        vii. Pancreatitis

5. There are no significant interacting drugs

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 a Non-Cancer Medications**

    2. **Off-Label Use of a Cancer Medication for the Treatment of Cancer without a Specific Coverage Guideline**

OCTREOTIDE ACETATE products, oral and injection

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.

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.

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Resources:

Mycapssa (octreotide acetate) product information, revised by Chiasma Inc. 06-2020. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 01, 2021.

Bynfezia Pen (octreotide acetate) product information, revised by Sun Pharmaceutical Industries, Inc. 04-2020. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 01, 2021.

Octreotide acetate product information, revised by Teva Parenteral Medicines, Inc 09-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 01, 2021.

Sandostatin (octreotide acetate) product information, revised by Novartis Pharmaceuticals Corporation 05-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 01, 2021.

Sandostatin LAR Depot (octreotide acetate) product information, revised by Novartis Pharmaceuticals Corporation 03-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 01, 2021.

Melmed S, Katznelson L. Diagnosis of acromegaly. In: UpToDate, Snyder PJ, Martin KA (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed August 24, 2021.

Melmed S, Katznelson L. Treatment of acromegaly. In: UpToDate, Snyder PJ, Martin KA (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed August 24, 2021.

Strosberg JS. Diagnosis of carcinoid syndrome and tumor localization. In: UpToDate, Tanabe KK, Whitcomb DC, Savarese DMF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed August 24, 2021.

Strosberg JS. Treatment of carcinoid syndrome. In: UpToDate, Tanabe KK, Whitcomb DC, Savarese DMF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed August 24, 2021.

Bergsland E. VOPoma: Clinical manifestations, diagnosis, and management. In: UpToDate, Tanabe KK, Whitcomb DC, Grover S (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Accessed August 24, 2021.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Neuroendocrine and Adrenal Tumors Version 3.2021 – Updated August 13, 2021. Available at https://www.nccn.org. Accessed August 24, 2021.

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.