

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

Reference Number: LA.PHAR.40

Effective Date: 08.20

Last Review Date: 04.22

Line of Business: 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, Bynfezia Pen™) is a somatostatin analogue.

FDA Approved Indication(s)

Sandostatin Injection and Bynfezia pen are indicated for:

- Acromegaly
 - 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;
- Carcinoid tumors*
 - 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
- Vasoactive intestinal peptide tumors* (VIPomas)
 - For the treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors

Sandostatin LAR Depot is indicated for treatment in patients who have responded to and tolerated Sandostatin Injection subcutaneous injection for:

- Acromegaly
- Carcinoid tumors (neuroendocrine tumors)
 - Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors
- Vasoactive intestinal peptide tumors* (VIPomas)
 - Profuse watery diarrhea associated with VIP-secreting tumors

Limitation(s) of use:

In patients with carcinoid syndrome and VIPomas, the effect of Sandostatin Injection, Bynfezia Pen, and Sandostatin LAR Depot on tumor size, rate of growth and development of metastases, has not been determined.

In patients with acromegaly, the effect of Bynfezia Pen on improvement in clinical signs and symptoms, reduction in tumor size and rate of growth, has not been determined.

Policy/Criteria

Prior authorization is required. 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 Louisiana Healthcare Connections that Sandostatin Injection, Bynfezia Pen 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. Prescribed by or in consultation with an endocrinologist;
3. Age \geq 18 years or, if younger, epiphyseal growth plates have closed;
4. 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;
5. Request is for one of the following formulations (*Sandostatin injection can be used with Sandostatin LAR Depot*) (a, b, or c):
 - a. Sandostatin Injection and Bynfezia Pen: Dose does not exceed 1,500 mcg per 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

B. Carcinoid Tumor - Neuroendocrine Tumor of the Gastrointestinal Tract, Lung and Thymus (must meet all):

1. Diagnosis of a carcinoid tumor (*most commonly arising in the lungs and bronchi, small intestine, appendix, rectum, or thymus*) and one of the following (a or b):
 - a. Request is for carcinoid syndrome (i.e., presence of diarrhea or flushing symptoms indicative of hormonal hypersecretion);
 - b. Request is for advanced disease, with or without carcinoid syndrome;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Request is for any of the following (*Sandostatin injection can be used with Sandostatin LAR Depot*) (a, b, or c):*
 - a. Sandostatin Injection and Bynfezia Pen: Dose does not exceed 1500 mcg per day in divided doses;
 - b. Sandostatin LAR Depot (i and ii):
 - i. Dose does not to exceed 30 mg every 4 weeks;
 - ii. If request is for symptom management only, member has received Sandostatin Injection for at least two weeks with improvement in diarrhea or flushing episodes;

- c. Dose for Sandostatin Injection, Bynfezia Pen, or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid— 6 months

C. Pancreatic Neuroendocrine Tumor (including VIPoma) and Adrenal Tumor (must meet all):

1. Diagnosis of one of the following (a or b):

- a. Pancreatic neuroendocrine tumor including but not limited to VIPoma, gastrinoma, insulinoma or glucagonoma, and one of the following (i, ii, iii, or iv):
 - i. Request is for management of symptoms indicative of hormonal hypersecretion (e.g., diarrhea);
 - ii. Request is for treatment of a gastrinoma with or without symptoms;
 - iii. For other pancreatic neuroendocrine tumors, request is for advanced disease, with or without symptoms;
 - iv. If request is for an insulinoma, tumor is somatostatin receptor positive on imaging;
 - b. Advanced adrenal pheochromocytoma/paraganglioma;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Request is for any of the following (*Sandostatin injection can be used with Sandostatin LAR Depot*) (a, b, or c):*
- i. Sandostatin injection and Bynfezia Pen: Dose does not exceed 750 mcg per day in divided doses;
 - a. Sandostatin LAR Depot (i and ii):
 - i. Dose does not exceed 30 mg every 4 weeks;
 - ii. If request is for symptom management only, member has received Sandostatin Injection for at least two weeks with improvement in symptoms prior to request for Sandostatin LAR Depot.
 - b. Dose for Sandostatin Injection, Bynfezia Pen or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid— 6 months

D. Meningioma (off-label) (must meet all):

- 1. Diagnosis of meningioma (*cancer of the central nervous system*);
- 2. Prescribed by or in consultation with an oncologist;
- 3. Age \geq 18 years;
- 4. Disease is not amenable to surgery or radiation;
- 5. Octreotide scan is positive;
- 6. Dose for Sandostatin Injection, Bynfezia Pen and/or Sandostatin LAR Depot is within FDA maximum limit for any FDA-approved indication or is supported by practice

guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid– 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 \geq 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/paclitaxel;
5. Dose for Sandostatin Injection, Bynfezia Pen and/or Sandostatin LAR Depot is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid– 6 months

F. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Acromegaly (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections 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 of the following (*Sandostatin injection can be used with Sandostatin LAR Depot*) (a, b, or c):
 - a. Sandostatin Injection and Bynfezia Pen: New dose does not exceed 1,500 mcg per day in divided doses;
 - b. Sandostatin LAR Depot: New dose does not exceed 40 mg every 4 weeks;

Approval duration:

Medicaid– 6 months

B. Carcinoid Tumor and Pancreatic/Adrenal Neuroendocrine Tumor (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Sandostatin Injection,

Bynfezia, or Sandostatin LAR Depot for a covered indication 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 meets one of the following (*Sandostatin Injection can be used with Sandostatin LAR Depot*) (a, b, or c):*
 - a. Sandostatin Injection and Bynfezia Pen (i or ii):
 - i. Carcinoid tumors: New dose does not exceed 1,500 mcg per day in divided doses;
 - ii. VIPomas: New dose does not exceed 750 mcg per day in divided doses;
 - b. Sandostatin LAR Depot: New dose does not exceed 30 mg every 4 weeks;
 - c. New dose for Sandostatin Injection, Bynfezia Pen, or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid – 6 months

C. Meningioma, Thymoma and Thymic Carcinoma (off-label) (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Sandostatin Injection, Bynfezia, or Sandostatin LAR Depot for a covered indication 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, new dose for Sandostatin Injection, Bynfezia Pen, and/or Sandostatin LAR Depot is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid – 6 months

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

1. Currently receiving medication via Louisiana Healthcare Connections 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 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

GH: growth hormone

IGF-1: insulin growth factor 1
(somatomedin C)

NCCN: National Comprehensive Cancer
Network

VIPoma: vasoactive intestinal peptide
tumor

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Sandostatin LAR Depot: None reported
- Sandostatin Injection and Bynfezia Pen:
 - Contraindication(s): Sensitivity to this drug or any of its components.
 - Boxed warning(s): None reported.

Appendix D: General Information

Acromegaly: 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 |
| | Carcinoid 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 |
| 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 |
| Bynfezia Pen (Octreotide acetate) (SC) | Acromegaly | Up to 1500 mcg in 3 divided doses | 1500 mcg/day |
| | Carcinoid tumors | Up to 1500 mcg in 2 to 4 divided doses | 1500 mcg/day |
| | VIPomas | Up to 750 mcg in 2 to 4 divided doses | 750 mcg/day |

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 |

| Drug Name | Availability |
|--|---|
| Octreotide acetate (Sandostatin LAR Depot) | Single-use kit (vial): 10 mg, 20 mg, 30 mg |
| Bynfezia Pen (Octreotide acetate) | Single-patient-use pen: 2,500 mcg/mL octreotide as a 2.8 mL |

VII. References

1. Sandostatin Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2021. Available at http://www.pharma.us.novartis.com/product/pi/pdf/sandostatin_inj.pdf. Accessed November 10, 2021.
2. Bynfezia Pen Prescribing Information. Gurjarat, India. Sun Pharmaceuticals; January 2020. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/213224s0001bl.pdf. Accessed November 10, 2021.
3. Sandostatin LAR Depot prescribing information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2021. Available at http://www.pharma.us.novartis.com/product/pi/pdf/sandostatin_lar.pdf. Accessed November 10, 2021.

Acromegaly

4. Katznelson L, Laws Jr. ER, Melmed S, et al. Acromegaly: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014;99:3933-3951.
5. Melmed S, Colao A, Barkan A, et al. Guidelines for acromegaly management: an update. J Clin Endocrinol Metab. May 2009; 94(5): 1509-1517.

Oncology

6. Octreotide acetate [Sandostatin, Bynfezia]. National Comprehensive Cancer Network Compendium. Available at nccn.org. Accessed November 10, 2021.
7. Octreotide acetate (LAR) [Sandostatin LAR Depot]. National Comprehensive Cancer Network Compendium. Available at nccn.org. Accessed November 10, 2021.
8. National Comprehensive Cancer Network Guidelines. Neuroendocrine and Adrenal Tumors Version 3.2021. Available at nccn.org. Accessed November 10, 2021.
9. National Comprehensive Cancer Network Guidelines. Central Nervous System Cancers Version 2.2021. Available at nccn.org. Accessed November 10, 2021.
10. National Comprehensive Cancer Network Guidelines. Thymomas and Thymic Carcinomas Version 1.2021. Available at nccn.org. Accessed November 10, 2021.

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.

| HCPSC Codes | Description |
|-------------|---|
| J2353 | Injection, octreotide, depot form for intramuscular injection, 1 mg |

| HCPSC Codes | Description |
|-------------|--|
| J2354 | Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg |

| Reviews, Revisions, and Approvals | Date | LDH Approval Date |
|---|------------|-------------------|
| Converted corporate to local policy. | 08/15/2020 | 08.20 |
| 1Q 2021 annual review: advanced adrenal pheochromocytoma /paraganglioma added per NCCN; references reviewed and updated. Mycapssa removed from policy. | 01.21 | 04.21 |
| 1Q 2022 annual review: no significant changes; references reviewed and updated. | 04.22 | |

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. LHCC 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.

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