

Request for Prior Authorization for Sandostatin LAR Depot (octreotide acetate)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030

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.

Sandostatin LAR Depot (octreotide acetate) Prior Authorization Criteria:

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 diagnosis of **acromegaly** when 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:
 - 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 GH level \geq 1ng/mL following an oral glucose tolerance test (OGTT)
- Documentation of baseline growth hormone (GH) and IGF-I blood levels.
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
 - 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 diagnosis of **metastatic carcinoid tumors** when the following criteria is met:

- The member has severe diarrhea and/or flushing episodes (carcinoid syndrome)
- **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 diagnosis of **vasoactive intestinal peptide tumors (VIPomas)** when following criteria is met:

- The member has profuse watery diarrhea associated with VIP-secreting tumors
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
 - Member is experiencing a decrease in severity and occurrence of diarrhea
- **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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

