Clinical Policy: Octreotide Acetate (Sandostatin Injection, Sandostatin LAR Depot)
Reference Number: ERX.SPA.67
Effective Date: 03.01.14
Last Review Date: 02.19

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Octreotide acetate (Sandostatin® Injection, Sandostatin® LAR Depot) is a somatostatin analogue.

FDA Approved Indication(s)
Sandostatin Injection (SC/IV) is 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 (IM) is indicated for treatment in patients who have responded to and tolerated Sandostatin Injection for:
- Acromegaly
- Carcinoid tumors*
  - Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors
- Vasoactive intestinal peptide tumors* (VIPomas)
  - Profuse watery diarrhea associated with VIP-secreting tumors

*Neuroendocrine tumors.

Limitation(s) of use: In patients with carcinoid syndrome and VIPomas, the effect of Sandostatin Injection and Sandostatin LAR Depot on tumor size, rate of growth and development of metastases, has not been determined.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Sandostatin Injection 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. Age ≥ 18 years or, if younger, epiphyseal growth plates have closed;
3. 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;
4. Request is for either of the following formulations (both products may be used together) (a or b):
   a. Sandostatin Injection: 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: 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 ≥ 18 years;
   4. Request is for any of the following (both products may be used together) (a, b, or c):
      a. Sandostatin Injection: Dose does not exceed 1500 mcg per day in divided doses;
      b. 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 diarrhea or flushing episodes;
      c. Dose for Sandostatin Injection or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Approval duration: 6 months**

C. **Vasoactive Intestinal Peptide Tumor and other Pancreatic Neuroendocrine Tumors** (must meet all):
   1. Diagnosis of a pancreatic neuroendocrine tumor including but not limited to VIPoma, gastrinoma, insulinoma, or glucagonoma, and one of the following (a, b, or c):
      a. Request is for management of symptoms indicative of hormonal hypersecretion (e.g., diarrhea);
      b. Request is for treatment of a gastrinoma with or without symptoms;
      c. For other pancreatic neuroendocrine tumors, request is for advanced disease, with or without symptoms - if request is for an insulinoma, tumor is somatostatin receptor positive on imaging;
   2. Prescribed by or in consultation with an oncologist;
   3. Age ≥ 18 years;
   4. Request is for any of the following (both products may be used together) (a, b, or c):
      a. Sandostatin injection:
         i. Dose does not exceed 750 mcg per day in divided doses;
      b. 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;
      c. Dose for Sandostatin Injection or Sandostatin LAR Depot is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).
Approval duration: 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 ≥ 18 years;
4. Disease is not amenable to surgery or radiation;
5. Octreotide scan is positive;
6. Dose for Sandostatin Injection 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).

Approval duration: 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 ≥ 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 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).

Approval duration: 6 months

F. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Acromegaly (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met 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 either of the following (both products may be used together) (a or b):
   a. Sandostatin Injection: 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: 6 months

B. Carcinoid Tumor - Neuroendocrine Tumor of the Gastrointestinal Tract, Lung and Thymus; Vasoactive Intestinal Peptide Tumor and other Pancreatic Neuroendocrine Tumors (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Sandostatin or Sandostatin LAR for a carcinoid tumor or VIPoma 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 is for any of the following (both products may be used together) (a, b, or c):
   a. Sandostatin Injection (i or ii):
      i. Carcinoid tumors: New dose does not exceed 1500 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 to exceed 30 mg every 4 weeks.
c. New dose for Sandostatin Injection or Sandostatin LAR Depot is supported by practice
guidelines or peer-reviewed literature for the relevant off-label use (prescriber must
submit supporting evidence).

Approval duration: 6 months

C. Meningioma, Thymoma and Thymic Carcinoma (off-label) (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or
member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose for Sandostatin Injection 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).

Approval duration: 6 months

D. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions
and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III
(Diagnoses/Indications for which coverage is NOT authorized).

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 – ERX.PA.01 or
evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
GH: growth hormone
IGF-1: insulin growth factor 1 (somatomedin C)
VIPoma: vasoactive intestinal peptide tumor

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
Sandostatin LAR Depot: none reported

Sandostatin Injection:
- 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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Octreotide acetate</td>
<td>Acromegaly</td>
<td>Up to 1500 mcg in 2 or more divided doses</td>
<td>1500 mcg/day</td>
</tr>
<tr>
<td>(Sandostatin Injection)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SC or IV)</td>
<td>Carcinoid tumors</td>
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<td>1500 mcg/day</td>
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## Octreotide Acetate

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<th>Drug Name</th>
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<tbody>
<tr>
<td>VIPomas</td>
<td>Up to 750 mcg in 2 or more divided doses</td>
<td>750 mcg/day</td>
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<tr>
<td>Acromegaly</td>
<td>20-40 mg every 4 weeks</td>
<td>40 mg/4 weeks</td>
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</tr>
<tr>
<td>Carcinoid tumors</td>
<td>20-30 mg every 4 weeks</td>
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### VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
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<tbody>
<tr>
<td>Octreotide acetate (Sandostatin Injection)</td>
<td>Single-use ampule: 50 mcg/mL, 100 mcg/mL, 500 mcg/mL Multi-dose vial: 200 mcg/mL, 1000 mcg/mL</td>
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<tr>
<td>Octreotide acetate (Sandostatin LAR Depot)</td>
<td>Single-use kit (vial): 10 mg, 20 mg, 30 mg</td>
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</table>

### VII. References

### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Review Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created.</td>
<td>02.14</td>
<td>03.14</td>
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<tr>
<td>Policy converted to new template. For all three indications: age and dosing parameters added per PI; safety criteria and documentation requests removed; initial approval period increased to 3 months. Acromegaly: removed prospective question regarding stopping therapy; removed bromocriptine/cabergoline requirements; edited monitoring parameters to include IGF-1, GH and tumor mass; removed requirement that member have clinical evidence of acromegaly per App B. Carcinoid tumors: clarified that carcinoid tumors are now known as neuroendocrine tumors of the GI tract, lung, and thymus; removed requirement that member be experiencing carcinoid syndrome; removed question about whether member is a candidate for surgery as surgery can be used with octreotide to cure or control. VIPomas: as with carcinoid tumors, questions about surgery are removed. 1Q18 annual review: Age edited to include adolescents with closed epiphyseal plates.</td>
<td>07.16</td>
<td>09.16</td>
</tr>
<tr>
<td>1Q18 annual review: Age edited to include adolescents with closed epiphyseal plates.</td>
<td>11.30.17</td>
<td>02.18</td>
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### Reviews, Revisions, and Approvals

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<th>Date</th>
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<tbody>
<tr>
<td>1Q 2019 annual review: off-label NCCN recommended uses added for tumor control of neuroendocrine tumors with or without symptoms; positive octreotide scan added for meningioma per NCCN; references reviewed and updated.</td>
<td>11.13.18 02.19</td>
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</tbody>
</table>

**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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

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