Pharmacy Drug Policy Checklist

POLICY NAME	Sandostatin (octreotide) and Sandostatin LAR	POLICY #	1741P

Criteria

Coverage Criteria for the Treatment of Acromegaly

- ☐ **1.1** Prescribed by an endocrinologist (hormone doctor)
- ☐ **1.2** Diagnosis of acromegaly
- ☐ **1.3** High Insulin-like Growth Factor (IGF-1) levels for age (lab values are required)
- ☐ **1.4** Documented inadequate response to surgery or radiotherapy or clinical reason why the patient has not had surgery or radiotherapy
- ☐ **1.5** If request is a new start for Sandostatin LAR, documented 2-week treatment with Sandostatin injection which was effective and tolerated

Coverage Criteria for the Treatment of High-Grade Poorly-Differentiated Neuroendocrine Tumor (NET)

- ☐ **2.1** Prescribed by an specialist knowledgeable in the treatment of NETs
- ☐ **2.2** Sandostatin/Sandostatin LAR will be used in addition cancer therapy

Coverage Criteria for the Treatment of Well Differentiated (Carcinoid) NET

- ☐ **3.1** Prescribed by an specialist knowledgeable in the treatment of NETs
- ☐ **3.2** Diagnosis of one of the following:
  - Metastatic disease for which surgery cannot be performed
  - Cancer releasing tumors
  - Significant tumor burden
  - Abnormal lung tumors despite cancer treatment
  - Lung NET with positive octreotide scan

Coverage Criteria for the Treatment of Pancreatic NET

- ☐ **4.1** Prescribed by an specialist knowledgeable in the treatment of NETs
- ☐ **4.2** Diagnosis of one of the following:
  - Insulinoma (pancreas tumors)

- Gastrinoma (intestinal tumors) Pharmacy Drug Policy & Procedure
- VIPoma (endocrine tumors)
- Pituitary adenoma (pituitary tumors)

Coverage Criteria for the Treatment of Acute Chemotherapy-Related Diarrhea

- ☐ **5.1** Prescribed by an oncologist (cancer doctor) or hematologist (blood disorder doctor)
- ☐ **5.2** Documentation that the member is currently receiving a chemotherapy regimen
- ☐ **5.3** Documented trial and failure, intolerance, or contraindication to loperamide (generic for Imodium) or diphenoxylate-atropine (generic for Lomotil)

Coverage Criteria for the Treatment of Diarrhea Associated with Graft-Versus-Host Disease (GVHD)

- ☐ **6.1** Prescribed by an oncologist (cancer doctor) or hematologist (blood disorder doctor)
- ☐ **6.2** Diagnosis of steroid-refractory gut GVHD
- ☐ **6.3** Documented trial and failure, intolerance, or contraindication to loperamide (generic for Imodium) or diphenoxylate-atropine (generic for Lomotil)