Pharmacy Drug Policy Checklist

POLICY NAME	Somatuline Depot (lanreotide acetate)	POLICY #	2480P

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** Documented trial and failure or contraindication to Sandostatin or Sandostatin LAR

Coverage Criteria for the Treatment of High-Grade Poorly-Differentiated NET

- ☐ **2.1** Prescribed by a specialist knowledgeable in the treatment of NETs
- ☐ **2.2** Somatuline will be used in conjunction with cancer treatment

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

- ☐ **3.1** Prescribed by a specialist knowledgeable in the treatment of NETs
- ☐ **3.2** Diagnosis of one of the following: spreading unresectable disease, cancer releasing tumors, significant tumor burden, abnormal lung tumors despite cancer treatment, or 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)
  - VIPoma (endocrine tumors)
  - Pituitary adenoma (pituitary tumors)