

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)