POLICY NUMBER UM ONC_1042	**SUBJECT** Somatostatin Analog: Sandostatin™ (octreotide) and Somatuline™ (lanreotide)		**DEPT/PROGRAM** UM Dept	**PAGE 1 OF 2**
DATES COMMITTEE REVIEWED 01/12/11, 03/08/12, 11/13/13, 03/05/15, 03/27/15, 04/11/16, 02/06/17, 12/28/17, 01/10/18, 02/06/19, 12/11/19, 02/12/20	**APPROVAL DATE** February 12, 2020	**EFFECTIVE DATE** March 01, 2020	**COMMITTEE APPROVAL DATES** (latest version listed last) 01/12/11, 03/08/12, 11/13/13, 03/05/15, 03/27/15, 04/11/16, 02/06/17, 12/28/17, 01/10/18, 02/06/19, 12/11/19, 02/12/20	
PRIMARY BUSINESS OWNER: UM **APPROVED BY:** Dr. Andrew Hertler		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee		
URAC STANDARDS		**NCQA STANDARDS** UM 2	**ADDITIONAL AREAS OF IMPACT**	
CMS REQUIREMENTS	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** All	

I. PURPOSE

To define and describe the accepted indications for Somatostatin analogs usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century is responsible for processing all medication requests from network ordering providers. Medications not authorized by New Century may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

1. **Unless contraindications, intolerance, or failure exist, the PREFERRED Somatostatin analog for all indiccations is Sandostatin (octreotide) over Somatuline (lanreotide).**
2. **Neuroendocrine and Adrenal Tumors**
    a. Somatostatin Analog is being used in member with any of the following:
        i. Management of unresectable locoregional disease and/or distant metastases for the following:
            a) As symptom control in members with carcinoid syndrome **AND/OR**
            b) For tumor control.
3. **Thymomas and Thymic Carcinomas**
    a. The member has thymomas or thymic carcinomas and Sandostatin SQ or LAR depot (octreotide) is being used as second line therapy for locally advanced with or without prednisone.
4. **Meningiomas**
    a. Sandostatin SQ or LAR depot (octreotide) is being used for recurrent or progressive disease, when radiation is not possible, and octreotide scan positive.

III. EXCLUSION CRITERIA

1. Dosing exceeds single dose limit of 40 mg Sandostatin LAR depot (octreotide) or 500 mcg of Sandostatin SQ (Octreotide).
2. Dosing exceeds single dose limit Somatuline (lanreotide) 120 mg.
3. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

III. MEDICATION MANAGEMENT

Please refer to the FDA label/package insert for details regarding these topics.

IV. APPROVAL AUTHORITY

1. Review – UM Department
2. Final Approval – UM Committee

V. ATTACHMENTS

None

VII. REFERENCES

1. Sandostatin prescribing information. Novartis Pharmaceuticals Corporation. East Hanover, New Jersey. 2019.
2. Sandostatin LAR depot prescribing information. Novartis Pharmaceuticals Corporation. East Hanover, New Jersey. 2019.
3. Somatuline (lanreotide) prescribing information. Ipsen Biopharmaceuticals, Inc. 2019.
4. Clinical Pharmacology Elsevier Gold Standard. 2020.
5. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2020.
6. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2020.
7. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2020.