Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	November 12, 2021 January 19, 2022

OCTREOTIDES & RELATED AGENTS

Preferred Drugs: Octreotide acetate injection

Non-preferred Drugs: Mycapssa® (octreotide), Sandostatin® (octreotide acetate), Sandostatin® LAR Depot (octreotide acetate), Signifor® (pasireotide) injection, Signifor® LAR (pasireotide) for injectable suspension, Somatuline® Depot (lanreotide) injection

LENGTH OF AUTHORIZATION: Initial therapy: 3 months
Continuation of therapy: Up to one year

INITIAL REVIEW CRITERIA:

- Medication requested must have the FDA approved indication and the patient must be within the FDA approved age limits.
- Quantity and age limits are located on the Summary of Drug Limitations at the following website: https://ahca.myflorida.com/medicaid/Prescribed_Drug/preferred_drug.shtml

Acromegaly:

- Patient must have a confirmed diagnosis of Acromegaly.
- Documented response and tolerability to treatment with octreotide acetate or lanreotide injection prior to use.
- Patient is either ineligible for or has had an inadequate response to surgery or radiation.

Carcinoid Tumors or Vasoactive Intestinal Peptide Tumors (VIPomas):

- Patient must have confirmed diagnosis of Carcinoid Syndrome.
- Patient has severe flushing/diarrhea episodes associated with a metastatic carcinoid tumor.
- Profuse watery diarrhea associated with Vasoactive Intestinal Peptide secreting tumors.
- Baseline flushing episodes ≥ 3 daily **OR** baseline stools ≥ 4 daily.

Cushing's Disease:

- Patient has a confirmed diagnosis of Cushing's disease.
- Patient is ineligible for pituitary surgery or surgery has not been curative.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/