Reference number(s)
4256-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☐
Standard Control – Choice (SCCF)	☐
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☐
Advanced Control Specialty – Choice (ACSCF)	☐
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☐

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☑
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Acromegaly Products

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Medical Benefit.

Plan Design Summary

This program applies to the acromegaly products specified in this document. Coverage for a targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Acromegaly Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Products
Preferred	• Sandostatin LAR (octreotide acetate for injectable suspension) • Somatuline Depot (lanreotide)

	Products
Targeted	• Lanreotide Injection • Signifor LAR (pasireotide injectable suspension) • Somavert (pegvisomant)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for both of the preferred products.

Lanreotide Injection

Coverage for the targeted product is provided when all of the following criteria are met:

- The member has had a documented intolerable adverse event to Somatuline Depot, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
- The member has a documented inadequate response or intolerable adverse event to Sandostatin LAR.

Signifor LAR, Somavert

Coverage for a targeted product is provided when the member has had a documented inadequate response or intolerable adverse event to any of the preferred products.

References

1. Somatuline Depot [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; July 2024.
2. Sandostatin LAR Depot [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2024.
3. Signifor LAR [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Company; July 2024.
4. Somavert [package insert]. New York, NY: Pharmacia & Upjohn Co; July 2023.
5. Lanreotide Injection [package insert]. Warren, NJ: Cipla USA, Inc.; May 2024.