Reference number(s)
2749-A

STANDARD MEDICARE PART B MANAGEMENT

SIGNIFOR LAR (pasireotide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
   1. Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option
   2. Treatment of patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative

B. Compendial Uses
   1. Carcinoid syndrome
   2. Metastatic neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract (carcinoid tumors)

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. DOCUMENTATION

The following documentation must be available, upon request, for all submissions:

A. Acromegaly:
   1. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or a clinical reason for not having surgery.
   2. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy

B. Cushing's disease:
   1. For initial requests, pretreatment cortisol level as measured by one of the following tests:
      a. Urinary free cortisol (UFC)
      b. Late-night salivary cortisol
      c. 1 mg overnight dexamethasone suppression test (DST)
      d. Longer, low dose DST (2mg per day for 48 hours)
   2. For continuation of therapy, current cortisol level as measured by one of the following tests:
      a. Urinary free cortisol (UFC)
      b. Late-night salivary cortisol
      c. 1 mg overnight dexamethasone suppression test (DST)
      d. Longer, low dose DST (2mg per day for 48 hours)

III. CRITERIA FOR INITIAL APPROVAL

A. Acromegaly

Authorization of 12 months may be granted for treatment of acromegaly when all of the following criteria are met:

1. Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range.
2. Member has had an inadequate or partial response to surgery OR there is a clinical reason why the member has not had surgery.

B. Cushing's disease

Authorization of 12 months may be granted for treatment of Cushing's disease when the member has had surgery that was not curative OR the member is not a candidate for surgery.

C. Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract (carcinoid tumors)

Authorization of 12 months may be granted for treatment of metastatic NETs of the GI tract (carcinoid tumors).

D. Carcinoid syndrome

Authorization of 12 months may be granted for treatment of carcinoid syndrome.

IV. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

A. The member is currently receiving therapy with Signifor LAR.
B. Signifor LAR is being used to treat an indication enumerated in Section II.
C. The member is receiving benefit from therapy. Benefit is defined as:
    1. Acromegaly: decreased or normalized IGF-1 level since initiation of therapy.
    2. Cushing's disease (any of the following):
        a. Lower cortisol levels since the start of therapy per one of the following tests:
            i. Urinary free cortisol (UFC)
            ii. Late-night salivary cortisol
            iii. 1 mg overnight dexamethasone suppression test (DST)
            iv. Longer, low dose DST (2mg per day for 48 hours)
        b. Improvement in signs and symptoms of the disease
    3. All other indications: improvement or stabilization on clinical signs and symptoms since initiation of therapy

V. REFERENCES

1. Signifor LAR [package insert]. Lebanon, NJ: Recordati Rare Diseases Inc; June 2020.
2. IBM Micromedex® DRUGDEX® (electronic version). IBM Watson Health, Greenwood Village, Colorado. Updated periodically. https://www.micromedexsolutions.com [available with subscription]. Accessed November 18, 2021.

3. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab.* 2014;99:3933-3951.
4. American Association of Clinical Endocrinologists Acromegaly Guidelines Task Force. Medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. *Endocr Pract*. 2011;17(suppl 4):1-44.
5. Nieman LK, Biller BM, Findling JW, et al. Treatment of Cushing's syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2015;100(8):2807-31.
6. Gadelha MR, Bronstein MD, Brue T, et al. Pasireotide versus continued treatment with octreotide or lanreotide in patients with inadequately controlled acromegaly (PAOLA): a randomized, phase 3 trial. *Lancet Diabetes Endocrinol*. 2014;2:875-84.
7. Colao A, Bronstein MD, Freda P, et al. Pasireotide versus octreotide in acromegaly: a head-to-head superiority study. *J Clin Endocrinol Metab.* 2014;99:791–799.