octreotide subcutaneous injection (SANDOSTATIN)

Diagnoses Considered for Coverage:

- Acromegaly
- Carcinoid syndrome
- Vasoactive intestinal peptide tumors
- AIDS-associated diarrhea
- Bleeding esophageal varices
- Chemotherapy-induced diarrhea
- Chylothorax
- Cryptosporidiosis
- Dumping syndrome
- Intestinal obstruction (malignant)
- Neuroendocrine tumors: GI Tract, Lung, and Thymus
- Neuroendocrine tumors of the pancreas
- Lymphorrhagia
- Pancreatitis, necrotizing
- Paraganglioma
- Pheochromocytoma and paraganglioma, advanced
- Pituitary adenomas (TSH-secreting)
- Prevention of postoperative complications of pancreatic surgery
- Polycystic Ovary Syndrome (PCOS)
- Radiation-induced diarrhea
- Thymoma
- Zollinger-Ellison syndrome

Coverage Criteria:

For acromegaly:

- Prescribed or recommended by an endocrinologist, **and**
- Dose does not exceed 1500 mcg per day.

Coverage Duration: length of benefit

For non-infectious diarrhea associated with HIV:

Initial Treatment
• Patient is currently receiving anti-retroviral therapy (ART) for HIV, **and** • Other etiology (i.e. infection, underlying GI disease, malabsorption) for

diarrheal symptoms has been ruled-out**, and**
- Inadequate response, intolerable side effect, or contraindication with loperamide (Imodium) or diphenoxylate/ atropine (Lomotil)*,* **and**
- Inadequate response, intolerable side effect, or contraindication with Mytesi (crofelemer), **and**
- Dose does not exceed 1800 mcg per day.

Coverage Duration: 1 month

Reauthorization

- Patient is responding to therapy, **and**
- Dose does not exceed 1800 mcg per day

Coverage Duration: one year

For diagnosis of intestinal obstruction:

Initial Treatment

- Intestinal obstruction is due to malignancy, **and**
- Dose does not exceed 400 mcg per day.

Coverage Duration: 2 weeks

Reauthorization

- Patient is responding to therapy, **and**
- Dose does not exceed 400 mcg per day.

Coverage Duration: 6 months

For all other diagnoses considered for coverage:

Initial Treatment

- Dose is appropriate for diagnosis.

Coverage Duration: 2 weeks

Reauthorization

- Patient is responding to therapy, **and**
- Dose is appropriate for diagnosis.

	Coverage Duration: 6 months

Coverage Duration: see above

Effective Date: 1/31/2024