Lanreotide
(Somatuline® Depot)
(generic, Cipla manufacturer)

Place of Service

Office Administration
Infusion Center Administration
Home Infusion Administration
Outpatient Facility Infusion Administration

HCPCS
Samatuline Depot: **J1930** per 1 mg
Lanreotide (Cipla manufacturer): **J1932** per 1 mg

Conditions listed in policy (*see criteria for details*)

- Acromegaly
- Carcinoid syndrome / Neuroendocrine tumors: GI tract, lung, and thymus
- Neuroendocrine tumors of the pancreas
- Pheochromocytoma and paraganglioma
- Zollinger Ellison syndrome /Gastrinoma

AHFS therapeutic class: Other miscellaneous therapeutic agents

Mechanism of action: Somatuline® (lanreotide) is an analog of natural somatostatin, thereby inhibiting GH secretion by binding to specific receptors for somatostatin and its analogs.

(1) Special Instructions and pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review via fax.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Somatuline® Depot (lanreotide) for conditions NOT listed in section 3 must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Acromegaly

1. Being prescribed by or in consultation with an endocrinologist

Covered Doses
Up to 120 mg SC every 4 weeks

Coverage Period
Cover Indefinitely

ICD-10:
E22.0, E34.4

Carcinoid syndrome / Neuroendocrine tumors of the GI Tract, Lung, and Thymus

Covered Doses
Up to 120 mg SC every 4 weeks

Coverage Period
Cover Indefinitely

ICD-10:
C7A.019, C7A.010 -12, C7A0.29, C7A.020-26, C7A.00, C7A.090-96, C7A.098, C7A.1, C7A.8, D3A.019, D3A.010-12, D3A.029, D3A.020- D3A.026, D3A.00, D3A.8, D3A.090-92, C7B3.00, C7B.01-04, C7B.09, C7B.8, E34.0, Z85.020, Z85.030, Z85.040, Z85.060, Z85.110, Z85.230, Z85.520, Z85.821

Neuroendocrine tumors of the pancreas

Covered Doses
Up to 120 mg SC every 4 weeks

Coverage Period
Cover Indefinitely

ICD-10:
C25.4, E08.649, E16.0, E16.1, E16.3, E16.8, Z85.068, Z85.07, Z85.09, Z85.858, Z85.020, Z85.030, Z85.040, Z85.060, Z85.110, Z85.230, Z85.520, Z85.821

Pheochromocytoma and paraganglioma

Covered Doses
Up to 120 mg SC every 4 weeks

Coverage Period
Cover Indefinitely

ICD-10:
C74.10-C74.12, C74.90-C74.92, C75.5, C7B.8

Zollinger-Ellison syndrome / Gastrinoma

Covered Doses
Up to 120 mg SC every 4 weeks

Coverage Period
Cover Indefinitely

ICD-10:
D3A.092, E16.4

(3) The following condition(s) DO NOT require Prior Authorization/Preservice
All requests for Somatuline® Depot (lanreotide) for conditions NOT listed in section 3 must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How Supplied:
60, 90 and 120 mg (single-use, pre-filled syringes)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.thomsonhc.com
- Lanreotide (Cipla) [Prescribing Information]. Warren, NJ: Basking Ridge, NJ: Cipla USA, Inc.; 12/2021.
- National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors (Version 1.2023). Available at: www.nccn.org.
- Somatuline Depot (lanreotide) [Prescribing Information]. Cambridge, MA: Ipsen Pharmaceuticals, Inc.; 2/2023.

(7) Policy Update

Date of last review: 4Q2023

Date of next review: 4Q2024

Changes from previous policy version:

- No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee