lanreotide

Commercial Medical Benefit Drug Policy

For oncology-related indications, medical necessity criteria can be found here: Blue Shield Oncology-Related Medication Policies.

For PPO, Direct Contract HMO, and when applicable, ASO, and Shared Advantage: Please access Evolent's CarePro Provider Portal to submit your request.

lanreotide (Somatuline Depot)
lanreotide, Cipla manufacturer

Place of Service
Office Administration
Infusion Center Administration
Home Infusion Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)
Mechanism of Action: An analog of natural somatostatin, inhibits GH secretion by binding to specific receptors for somatostatin and its analogs
HCPCS:
J1930:Injection, lanreotide, 1 mg
J1932:Injection, lanreotide, (cipla), 1 mg
How Supplied:
60 mg/0.2 mL, 90 mg/0.3 mL, and 120 mg/0.5 mL single-dose prefilled syringes

Condition(s) listed in policy *(see coverage criteria for details)*

- Acromegaly
- Zollinger-Ellison Syndrome/Gastrinoma

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

Acromegaly

Meets medical necessity if all the following are met:

1. Being prescribed by or in consultation with an endocrinologist

Covered Doses:
120 mg given subcutaneously every 4 weeks

Coverage Period:
Indefinite

ICD-10:
E22.0, E34.4

The following condition(s) DO NOT require Prior Authorization/Preservice if ALL its parameters are met, otherwise Prior Authorization/Preservice is required.

Zollinger-Ellison Syndrome/Gastrinoma

Covered Doses:
120 mg given subcutaneously every 4 weeks

ICD-10:
D3A.092, E16.4

References

1. AHFS. Available by subscription at http://www.lexi.com
2. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. Lanreotide (Cipla) [Prescribing Information]. Cipla USA, Inc., Warren, NJ. 12/2021.
4. Somatuline Depot (lanreotide) [Prescribing Information]. Ipsen Pharmaceuticals, Inc., Cambridge, MA. 7/2024.

Review History

Date of Last Annual Review: 4Q2024
Changes from previous policy version:

- For oncology-related indications, medical necessity criteria can be found here: Blue Shield Oncology-Related Medication Policies.
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Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee