

octreotide (Sandostatin IV or LAR Depot)

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.

Place of Service

Sandostatin IV

Home Infusion Administration
Hospital Administration
Infusion Center Administration
Outpatient Facility Infusion Administration

Sandostatin LAR Depot - IM only

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

Drug Details

USP Category: HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)

Mechanism of Action: Octreotide is a synthetic polypeptide structurally and pharmacologically related to somatostatin (growth hormone [somatotropin] release inhibiting factor)

HCPCS:

J2353:Injection, octreotide, depot form for intramuscular injection, 1 mg

J2354:Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg

How Supplied:

- Sandostatin:
 - 50 mcg, 100 mcg, or 500 mcg single-dose 1 mL ampuls
 - 1000 mcg or 5000 mcg multi-dose vial
- Sandostatin LAR: 10 mg, 20 mg or 30 mg single-use vials

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

- Acromegaly
- AIDS-Associated Diarrhea
- Bleeding Esophageal Varices
- Cryptosporidiosis
- Dumping Syndrome
- Lymphorrhagia
- Malignant Intestinal Obstruction
- Pancreatitis, necrotizing
- Pituitary Adenomas (TSH-Secreting)

- Polycystic Ovary Syndrome (PCOS)
- Prevention of Postoperative Complications of Pancreatic Surgery
- 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.

Sandostatin given by subcutaneous injection: Refer to the "Self-Administered Drugs" policy

Sandostatin given intravenously and Sandostatin LAR Depot are managed under the Medical Benefit.

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:

Sandostatin IV: Not to exceed to 1500 mcg per day

Sandostatin LAR Depot IM: Not to exceed 40 mg every 4 weeks

Coverage Period:

Sandostatin IV:

Initial: 2 weeks

Reauthorization: Every 6 months, based on continued response to therapy

Sandostatin LAR Depot IM: Yearly, based on continued response to therapy

ICD-10:

E22.0, E34.4

AIDS-Associated Diarrhea

Meets medical necessity if all the following are met:

1. Patient is currently stable on an anti-retroviral therapy (ART) regimen for 1 month or more

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2. Provider attestation for infectious cause for diarrhea symptoms or other treatable causes (e.g. malabsorption, underlying GI disease requiring treatment) have been ruled out
3. Patient has inadequate response, intolerance, or contraindication to regular use of generic Lomotil or loperamide (OTC)
4. Patient has inadequate response, intolerance, or contraindication to Mytesi (crofelemer)

Covered Doses:

Sandostatin IV: Not to exceed 1500 mcg per day

Sandostatin LAR IM: Not to exceed 40 mg every 4 weeks

Coverage Period:

Yearly, based on continued response to therapy

ICD-10:

K52.2, K52.89, R19.7 + HIV infection B20 or B97.35

Prevention of Postoperative Complications of Pancreatic Surgery

Meets medical necessity if all the following are met:

1. Being used to prevent complications of pancreatic surgery (i.e., abscess formation, sepsis, acute pancreatitis, pancreatic fistula, and peripancreatic fluid collection)

Covered Doses:

Sandostatin IV: Not to exceed 300 mcg per day

Coverage Period:

Initial: 2 weeks

Reauthorization: Every 6 months, based on continued response to therapy

ICD-10:

BF1, ODB, ODJ, OWJ, OF1, OF5, OF7, OF8, OF9, OFB, OFC, OFF, OFH, OFJ, OFL, OFM, OFP-OFW

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

Bleeding Esophageal Varices

Covered Doses:

Sandostatin IV: Not to exceed 1200 mcg per day

Sandostatin LAR IM: Not to exceed 40 mg every 4 weeks

ICD-10:

I85.01-I85.11

Cryptosporidiosis

Covered Doses:

Sandostatin IV: Not to exceed 2400 mcg per day

ICD-10:

A07.2

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Dumping Syndrome

Covered Doses:

Sandostatin IV: Not to exceed 600 mcg per day

Sandostatin LAR IM: Not to exceed 20 mg every 4 weeks

ICD-10:

K91.1

Lymphorrhagia

Covered Doses:

Sandostatin IV: Not to exceed 300 mcg per day

ICD-10:

R59

Malignant Intestinal Obstruction

Covered Doses:

Sandostatin IV: Not to exceed 900 mcg per day

Sandostatin LAR: Not to exceed 40 mg every 4 weeks

ICD-10:

K50.012-K56.69

Pancreatitis, necrotizing

Covered Doses:

Sandostatin IV: Not to exceed 1200 mcg per day

ICD-10:

K85.91, K85.92

Pituitary Adenomas (TSH-Secreting)

Covered Doses:

Sandostatin IV: Not to exceed 1500 mcg per day

Sandostatin LAR IM: Not to exceed 40 mg every 4 weeks

ICD-10:

E23.6

Polycystic Ovary Syndrome (PCOS)

Covered Doses:

Sandostatin IV: Not to exceed 300 mcg per day

ICD-10:

E28.2

Zollinger-Ellison Syndrome (Gastrinoma)

Covered Doses:

Sandostatin IV: Not to exceed 2000 mcg per day

Sandostatin LAR IM: Not to exceed 60 mg 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. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors (Version 2.2025). Available at <http://www.nccn.org>.
4. National Comprehensive Cancer Network. Palliative Care (Version 2.2025). Available at <http://www.nccn.org>.
5. Scarpellini E, Arts J, Karamanolis G, et al. International consensus on the diagnosis and management of dumping syndrome. *Nat Rev Endocrinol*. 2020 Aug;16(8):448-466. doi: 10.1038/s41574-020-0357-5. Epub 2020 May 26.
6. National Institute of Diabetes and Digestive and Kidney Diseases. Treatment of Dumping Syndrome. <https://www.niddk.nih.gov/health-information/digestive-diseases/dumping-syndrome/treatment>. Accessed August 15, 2025.
7. Sandostatin LAR Depot (octreotide injection suspension) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2024.
8. Sandostatin (octreotide injection solution) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2024.
9. Yavuz MN, Yavuz AA, Aydin F, et al: The efficacy of octreotide in the therapy of acute radiation-induced diarrhea: a randomized controlled study. *Int J Radiat Oncol Biol Phys* 2002; 54(1):195-202.

Review History

Date of Last Annual Review: 4Q2025

Changes from previous policy version:

- Request to use this drug for oncology-related indications should be directed to Evolent

*Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee*