blue california
Promise Health Plan

lanreotide

Medical Benefit Drug Policy

For oncology-related indications, coverage will be made based on medical necessity. Medical necessity determinations are made based on U.S. Food and Drug Administration (FDA) labeling, peer-reviewed medical literature, Medi-Cal coverage guidelines, and Centers for Medicare & Medicaid Services (CMS) approved compendia support (i.e., Clinical Pharmacology, National Comprehensive Cancer Network® (NCCN), American Hospital Formulary Service Drug Information, Thomson Micromedex DrugDex,® and Lexicomp®).

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 California Code of Regulations (CCR), Title 22, Section 51303 and 51313 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.

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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:
Not to exceed 120 mg given subcutaneously every 4 weeks

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
E22.0, E34.4

Zollinger-Ellison Syndrome/Gastrinoma

Meets medical necessity if all the following are met:

Covered Doses:
Not to exceed 120 mg given subcutaneously every 4 weeks

Coverage Period:
Yearly, based on continued response to therapy

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. 9/2024.
4. Somatuline Depot (lanreotide) Prescribing Information. Ipsen Pharmaceuticals, Inc., Cambridge, MA. 7/2024.

Review History

Date of Last Annual Review: 2Q2026

Changes from previous policy version:

- No clinical change following annual review.

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