blue california
Promise Health Plan

pasireotide pamoate (Signifor LAR)

Medical Benefit Drug Policy

Place of Service

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

Drug Details

USP Category: HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)
Mechanism of Action: pasireotide is a synthetic analog of somatostatin which binds to somatostatin receptors resulting in inhibition of ACTH secretion and a resultant decrease in cortisol secretion
HCPCS:
C9399, J3490: pasireotide pamoate:Injection, pasireotide long acting, 1 mg
How Supplied:
10 mg, 20 mg, 30 mg, 40 mg, and 60 mg (single-use, powder in a vial to be reconstituted with the provided 2 mL diluent)

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

- Acromegaly
- Cushing's Disease

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.

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

Acromegaly
Meets medical necessity if all the following are met:
1. Being prescribed by an endocrinologist

Covered Doses:
Up to 60 mg intramuscularly every 4 weeks

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
E22.0, E34.4

Cushing's Disease
Meets medical necessity if all the following are met:
1. Patient cannot undergo pituitary surgery or pituitary surgery has not been curative

Covered Doses:
Up to 40 mg intramuscularly every 4 weeks

Coverage Period:
Yearly, based on continued response to therapy

ICD-10:
E24.0, E24.3, E24.8, E24.9

References

1. AHFS®. Available by subscription at https://www.wolterskluwer.com/en/solutions/lexicomp
2. DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. Signifor LAR (pasireotide) [prescribing information]. Bridgewater, NJ: Recordati Rare Diseases Inc; July 2024.

Review History

Date of Last Annual Review: 3Q2025
Changes from previous policy version:
- No clinical changes following annual review.

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