



**GEORGIA MEDICAID FEE-FOR-SERVICE
OCTREOTIDE AND RELATED AGENTS PA SUMMARY**

Preferred	Non-Preferred
Isturisa (osilodrostat)	Bynfezia (octreotide pen)
Korlym (mifepristone tablets)	Mycapssa (octreotide delayed-release capsules)
Octreotide injection generic	Signifor (pasireotide)
Sandostatin LAR (octreotide extended-release)	Signifor LAR (pasireotide extended-release)
Xermelo (telotristat)	Somatuline Depot (lanreotide extended-release)
	Somavert (pegvisomant)

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- ❖ Preferred and non-preferred products require prior authorization (PA).
- ❖ **The PA criteria below is for Pharmacy Services only.**
Physicians administering medication in a clinic or office must bill the drug through Physician Services and not through Pharmacy Services. Information regarding the Providers' Administered Drug List (PADL) is located at www.mmis.georgia.gov and log in to request coverage from Physician Services.

PA CRITERIA:

Bynfezia

- ❖ Approvable for members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation.
- ❖ Approvable for members 18 years of age or older with a diagnosis of severe diarrhea and flushing episodes (carcinoid syndrome) associated with carcinoid tumors.
- ❖ Approvable for members 18 years of age or older with a diagnosis of profuse watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas).
- ❖ In addition, members or members' caregivers must have visual or manual dexterity impairment; otherwise, prescriber must submit a written letter of medical necessity stating the reason the preferred product, generic octreotide injection, is not appropriate for the member.

Isturisa

- ❖ Approvable for members 18 years of age or older with a diagnosis of Cushing's disease (syndrome) for whom pituitary surgery is not an option or has not been curative.

Korlym

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes or glucose intolerance secondary to hypercortisolism associated with



endogenous Cushing's syndrome who have failed surgery or who are not candidates for surgery.

- ❖ Female members of reproductive potential must have a negative pregnancy test confirmed within last 7 days and must use a non-hormonal method of contraception during treatment and for at least 1 month after the final dose.

Mycapssa

- ❖ For members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation and who have responded to and tolerated treatment with octreotide injection (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot), prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic octreotide injection and Sandostatin LAR, are not appropriate for the member.

Octreotide Injection Generic

- ❖ Approvable for members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation.
- ❖ Approvable for members 18 years of age or older with a diagnosis of severe diarrhea and flushing episodes (carcinoid syndrome) associated with carcinoid tumors.
- ❖ Approvable for members 18 years of age or older with a diagnosis of profuse watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas).
- ❖ Approvable for members 18 years of age or older with a diagnosis of chronic diarrhea associated with HIV/AIDS when infectious causes of diarrhea have been ruled out and the member has experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with antimotility agents (loperamide [Imodium], diphenoxylate/atropine [Lomotil]).

Sandostatin LAR

- ❖ Approvable for members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation.
- ❖ Approvable for members 18 years of age or older with a diagnosis of severe diarrhea and flushing episodes (carcinoid syndrome) associated with carcinoid tumors.
- ❖ Approvable for members 18 years of age or older with a diagnosis of profuse watery diarrhea associated with vasoactive intestinal peptide-secreting tumors (VIPomas).
- ❖ In addition, members must have responded to and tolerated octreotide injection (Sandostatin) for at least 2 weeks.

Signifor



- ❖ Approvable for members 18 years of age or older with a diagnosis of Cushing's disease (syndrome) for whom pituitary surgery is not an option or has not been curative.

Signifor LAR

- ❖ Approvable for members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation, and who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with octreotide injection (Sandostatin, Sandostatin LAR).
- ❖ Approvable for members 18 years of age or older with a diagnosis of Cushing's syndrome who pituitary surgery is not an option or has not been curative.

Somatuline Depot

- ❖ Approvable for members 18 years of older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation, and member must have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with octreotide injection (Sandostatin, Sandostatin LAR).
- ❖ Approvable for members 18 years or older with a diagnosis of carcinoid gastroenteropancreatic neuroendocrine tumors (GEP-NETs) whose tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic.
- ❖ Approvable for members 18 years or older with a diagnosis of severe diarrhea and flushing episodes (carcinoid syndrome) associated with carcinoid tumors, and member must have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with octreotide injection (Sandostatin, Sandostatin LAR).

Somavert

- ❖ Approvable for members 18 years of age or older with a diagnosis of acromegaly who have had an inadequate response to surgery or radiation, or who are not candidates for surgery and radiation, and who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with octreotide injection (Sandostatin, Sandostatin LAR).

Xermelo

- ❖ Approvable for members 18 years of age or older with a diagnosis of diarrhea associated with carcinoid syndrome (carcinoid tumors) who have tried a somatostatin analog for at least 3 months and are still experiencing 4 or more daily bowel movements when used in combination with a somatostatin analog.



EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.