Clinical Policy Title:	pasireotide
Policy Number:	RxA.478
Drug(s) Applied:	Signifor®, Signifor® LAR
Original Policy Date:	03/06/2020
Last Review Date:	03/09/2021
Line of Business Policy Applies to:	All lines of business

Background

Pasireotide (Signifor®, Signifor® LAR) is a somatostatin analog. It is indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

Signifor® LAR is indicated for the treatment of patients with:

- Acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option.
- Cushing's disease for whom pituitary surgery is not an option or has not been curative.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
pasireotide (Signifor®)	Cushing's disease	Initial: 0.6 mg or 0.9 mg SC twice daily Recommended dosing range: 0.3 mg to 0.9 mg SC twice daily	1.8 mg/day
pasireotide (Signifor® LAR)*	Cushing's disease	10 mg to 40 mg IM every 4 weeks	40 mg/4 weeks
	Acromegaly	40 mg to 60 mg IM every 4 weeks	60 mg/4 weeks

** Signifor® LAR must be administered by a healthcare professional.*

Dosage Forms

- Pasireotide (Signifor®): Single-dose ampules for injection: 0.3 mg/mL, 0.6 mg/mL, 0.9 mg/mL.
- Pasireotide (Signifor® LAR): Vial for reconstitution and injection: 10 mg, 20 mg, 30 mg, 40 mg, 60 mg.

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

A. Acromegaly (must meet all)**:**

1. Diagnosis of acromegaly;
2. Prescribed by or in consultation with an endocrinologist;

3. Age ≥ 18 years;
4. Request is for Signifor® LAR;
5. Inadequate response to surgical resection or pituitary irradiation (*see Appendix D*), or member is not a candidate for such treatment;
6. Dose does not exceed 60 mg (1 vial) every 4 weeks.

Approval duration
Commercial: 6 months
Medicaid: 6 months

B. Cushing's Disease (must meet all)**:**
1. Diagnosis of Cushing's disease;
2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Pituitary surgery was not curative;
   b. Member is not eligible for pituitary surgery;
5. Dose does not exceed one of the following (a or b):
   a. Signifor®: 1.8 mg (2 ampules) per day;
   b. Signifor® LAR: 40 mg (1 vial) every 4 weeks.

Approval duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Acromegaly (must meet all)**:**
1. Currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy (*see Appendix D*);
3. Request is for Signifor® LAR;
4. If request is for a dose increase, new dose does not exceed 60 mg (1 vial) every 4 weeks.

Approval duration
Commercial: 12 months
Medicaid: 12 months

B. Cushing's Disease (must meet all)**:**
1. Currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy (*see Appendix D*);
3. If request is for a dose increase, new dose does not exceed one of the following:
   a. Signifor®: 1.8 mg (2 ampules) per day;
   b. Signifor® LAR: 40 mg (1 vial) every 4 weeks.

Approval duration
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

APPENDIX B: Therapeutic Alternatives
Not applicable.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - None reported.

- Boxed Warning(s):
  - None reported.

APPENDIX D: General Information

- Treatment response for Cushing's disease may be defined as reduction in 24-hour urinary free cortisol (UFC) levels and/or improvement in signs or symptoms of the disease. Maximum urinary free cortisol reduction is typically seen by two months of treatment.
- Examples of treatment response to acromegaly therapy (including somatostatin analogs, surgical resection or pituitary irradiation) include improvement from baseline in or normalization of growth hormone (GH) and/or age- and sex-adjusted insulin-like growth factor (IGF-1) serum concentrations, or tumor mass control.

References

1. Signifor® Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2020. Available at: https://www.us.signifor.com/cushings-disease/. Accessed February 19, 2021.
2. Signifor® LAR Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2020. Available at https://www.hcp.novartis.com/products/signifor- lar/acromegaly/. Accessed February 19, 2021.
3. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014; 99(11): 3933-3951. Accessed February 19, 2021.
4. Melmed S, Colao A, Barkan A, et al. Guidelines for acromegaly management: An update. J Clin Endocrinol Metab. 2009; 94:1509–1517. Accessed February 19, 2021.
5. Katznelson L, Atkinson JLD, Cook DM, Ezzat SZ, Hamrahian AH, Miller KK. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. Endocrine Practice. 2011;17(Suppl 4). Accessed February 19, 2021
6. Nieman LK, Biller BMK, Findling JW, et al. Treatment of Cushing's syndrome: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2015; 100(8): 2807- 2831. Accessed February 19, 2021.
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8. Fleseriu, M., Biller, B.M.K., Freda, P.U. *et al.* A Pituitary Society update to acromegaly management guidelines. *Pituitary* 24, 1–13 (2021). https://doi.org/10.1007/s11102-020-01091-7. Accessed February 19, 2021.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy was established	01/2020	03/06/2020
Policy was reviewed: 1. Approval duration for commercial plan was updated:	05/2020	05/21/2020

- Initial approval: 6 months. - Continued therapy approval: 12 months. 2. Rephrased Continued Therapy criteria II.A.1. and II.B.1 to “currently receiving medication that has been authorized by RxAdvance benefit…”. 3. References were reviewed and updated.		
Policy was reviewed: 1. Policy title table was updated. 2. Continued therapy approval criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 3. References were updated.	02/19/2021	03/09/2021