Clover Health

EXCEPTIONS CRITERIA
ACROMEGALY PRODUCTS

PREFERRED PRODUCTS: SOMATULINE DEPOT, SANDOSTATIN LAR

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the acromegaly products specified in this policy. Coverage for a targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with the targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Acromegaly Products

	Product(s)
Preferred	• **Somatuline Depot** (lanreotide) • **Sandostatin LAR** (octreotide acetate for injectable suspension)
Targeted	• **Signifor LAR** (pasireotide) • **Somavert** (pegvisomant)

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for both of the preferred products.

Coverage for a targeted product is provided when either of the following criteria is met:

A. Member has received treatment with the requested targeted product in the past 365 days.
B. Member has a documented inadequate response or intolerable adverse event to any of the preferred products.

REFERENCES

1. Somatuline Depot [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; June 2019.
2. Sandostatin LAR Depot [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2019.
3. Signifor LAR [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Company; April 2019.
4. Somavert [package insert]. New York, NY: Pharmacia & Upjohn Co; August 2019.