SPECIALTY GUIDELINE MANAGEMENT

SIGNIFOR LAR (pasireotide injectable suspension)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

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.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for the treatment of acromegaly when all of the following criteria are met:

A. Member has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range.

B. Member had an inadequate or partial response to surgery OR there is a clinical reason why the member has not had surgery.

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member’s IGF-1 level has decreased or normalized since initiation of therapy.

IV. REFERENCES


