



PRIOR AUTHORIZATION POLICY

POLICY: Cushing's – Signifor Prior Authorization Policy

- Signifor™ (pasireotide subcutaneous injection – Novartis)

REVIEW DATE: 06/14/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Signifor, a somatostatin analog, is indicated for the treatment of **Cushing's disease** in adults for whom pituitary surgery is not an option or has not been curative.¹

Disease Overview

Cushing's syndrome refers to the general state of excessive levels of cortisol (hypercortisolism) in the blood.^{2,3} Hypercortisolism can occur for reasons that are either endogenous or exogenous in nature (e.g., Cushing's disease, cortisol-containing medications, adrenal gland tumor, certain cancers). Cushing's disease (hypercortisolism caused by pituitary adenomas) is the most common type of adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome. Treatment for Cushing's syndrome requires a multi-modal approach. The goals of treatment are normalization of cortisol excess, long-term disease control, avoidance of recurrence, and reversal of clinical features.⁴

Guidelines

The Endocrine Society published clinical practice guidelines (2015) for the treatment of Cushing's syndrome.⁵ First-line treatment involves resection of the tumor, unless surgery is not possible or is unlikely to meaningfully reduce excess glucocorticoid levels. In patients with ACTH-dependent Cushing's syndrome who underwent non-curative surgery or for whom surgery was not possible, the guidelines advocate

several second-line therapies (e.g., repeat transsphenoidal surgery, radiotherapy, medical therapy, and bilateral adrenalectomy). For Cushing's disease, the guidelines recommend medical therapies as second-line options after transsphenoidal surgery: steroidogenesis inhibitors (ketoconazole tablets, Metopirone® [metyrapone capsules], Lysodren® [mitotane tablets], etomidate injection) in patients either with or without radiotherapy/radiosurgery; pituitary-directed medical treatments (cabergoline tablets, Signifor) in patients who are not surgical candidates or who have persistent disease; and Korlym® (mifepristone tablets) in patients with diabetes or glucose intolerance who are not surgical candidates or who have persistent disease after transsphenoidal surgery.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Signifor. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Signifor as well as the monitoring required for adverse events and long-term efficacy, approval requires Signifor to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Signifor™ (pasireotide subcutaneous injection (Novartis) is(are) covered as medically necessary when the following criteria is(are) met for fda-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

- 1. Cushing's Disease.** Approve for the duration noted below if the patient meets ONE of the following criteria (A or B):
 - A) Initial Therapy.** Approve for 4 months if the patient meets the following criteria (i, ii, and iii):
 - i.** Patient is \geq 18 years of age; AND
 - ii.** According to the prescriber, the patient is not a candidate for surgery or surgery has not been curative; AND
Note: For patients with endogenous Cushing's syndrome awaiting surgery or therapeutic response after radiotherapy, see *Other Uses with Supportive Evidence*.
 - iii.** Signifor is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome.
 - B) Patient is Currently Receiving Signifor/Signifor LAR.** Approve for 1 year if the patient has had a response, as determined by the prescriber; and patient is continuing therapy to maintain response.

Other Uses with Supportive Evidence

2. Endogenous Cushing's Syndrome – Patient Awaiting Surgery. Approve for 4 months if the patient meets the following criteria (A and B):

A) Patient is \geq 18 years of age; AND

B) Signifor is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome.

3. Endogenous Cushing's Syndrome – Patient Awaiting Therapeutic Response After Radiotherapy. Approve for 4 months if the patient meets the following criteria (A and B):

A) Patient is \geq 18 years of age; AND

B) Signifor is prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome.

CONDITIONS NOT COVERED

Signifor™ (pasireotide subcutaneous injection (Novartis) is(are) considered experimental, investigational or unproven for ANY other use(s).

REFERENCES

1. Signifor® subcutaneous injection [prescribing information]. Lebanon, NJ: Recordati Rare Diseases; March 2020.
2. Sharma ST, Nieman LK, Feelders RA. Cushing's syndrome: epidemiology and developments in disease management. *Clin Epidemiol.* 2015;7:281-293.
3. Tritos NA, Biller BM. Advances in medical therapies for Cushing's syndrome. *Discov Med.* 2012;13(69):171-179.
4. Biller BMK, Grossman AB, Stewart PM, et al. Treatment of adrenocorticotropin-dependent Cushing's syndrome: A consensus statement. *J Clin Endocrinol Metab.* 2008;93:2454-2462.
5. Nieman LK, Biller BM, Findling JW. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2015;100(8):2807-2831.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	06/08/2022
Annual Revision	No criteria changes.	06/14/2023

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