



PRIOR AUTHORIZATION POLICY

POLICY: Somatostatin Analogs – Mycapssa Prior Authorization Policy

- Mycapssa® (octreotide delayed-release capsules – Amryt)

REVIEW DATE: 10/11/2023

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

Mycapssa, a somatostatin analog, is indicated for long-term maintenance treatment in **acromegaly** patients who have responded to and tolerated treatment with octreotide or lanreotide.¹ Mycapssa maintained growth hormone and insulin-like growth factor 1 levels in patients with acromegaly.

GUIDELINES

The Endocrine Society Clinical Practice Guidelines for Acromegaly (2014) recommend medical therapy as adjuvant treatment after surgical intervention.² Mycapssa is not addressed in the guidelines. Primary medical therapy with somatostatin analogs (no preferred agent) can be recommended for some patients (e.g., surgery is not curative or patient is a poor surgical candidate). Updated recommendations to the 2014 guidelines on therapeutic outcomes for patients with acromegaly were created by the Acromegaly Consensus Group (2017).³ The guidelines recommend Somatuline® Depot (lanreotide deep subcutaneous injection) and Sandostatin® LAR Depot (octreotide intramuscular injection) as first-line medical therapies in patients with persistent disease after surgery. Signifor® LAR (pasireotide intramuscular injection) is recommended as a second-line medical therapy due to its potential for hyperglycemic-associated adverse events. The Pituitary Society Acromegaly Management Guidelines (2020) recommend oral octreotide capsules as suitable for

patients who have demonstrated complete or partial biochemical response to injectable octreotide or lanreotide.⁴

POLICY STATEMENT

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

• **Mycapssa® (octreotide delayed-release capsules – Amryt) 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. Acromegaly. Approve for 1 year if the patient meets the following (A, B, and C):

A) Patient has (or had) a pretreatment (baseline) insulin-like growth factor 1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory; AND

Note: Pretreatment (baseline) refers to the IGF-1 level prior to the initiation of a somatostatin analog (e.g., Mycapssa [octreotide delayed-release capsules], an octreotide acetate injection product [e.g., Bynfezia Pen, Sandostatin {generic}, Sandostatin LAR Depot], Signifor LAR [pasireotide injection], Somatuline Depot [lanreotide injection], dopamine agonist [e.g., cabergoline, bromocriptine], or Somavert [pegvisomant injection]). Reference ranges for IGF-1 vary among laboratories.

B) According to the prescriber, patient has responded to one octreotide acetate injection product or Somatuline Depot (lanreotide injection); AND

C) The medication is prescribed by or in consultation with an endocrinologist.

CONDITIONS NOT COVERED

Mycapssa® (octreotide delayed-release capsules – Amryt) is(are) considered experimental, investigational or unproven for ANY other use(s).

REFERENCES

1. Mycapssa® capsules [prescribing information]. Scotland, UK: Amryt; March 2022.

2. Katznelson L, Laws ER Jr, Melmed S, et al; Endocrine Society. Acromegaly: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab.* 2014;99:3933-3951.
3. Melmed S, Bronstein M, Chanson P, et al. A consensus statement on acromegaly therapeutic outcomes. *Natural Reviews Endocrinology.* 2018;14(9):552-561.
4. Fleseriu M, Biller, BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary.* 2020; 24:1-13.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	09/14/2022
Annual Revision	No criteria changes.	10/11/2023

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