PRIOR AUTHORIZATION POLICY

POLICY: Somatostatin Receptor Agonist – Palsonify Prior Authorization Policy
- Palsonify™ (paltusotine tablets – Crinetics)

REVIEW DATE: 10/08/2025

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. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. 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

Palsonify, a somatostatin receptor agonist, is indicated for the treatment of adults with acromegaly who had an inadequate response to surgery and/or for whom surgery is not an option.[1]

GUIDELINES

The current guidelines do not address Palsonify. The Pituitary Society guidelines on acromegaly management (2021) emphasize a personalized approach to medication management, especially for patients who are not surgical candidates or have residual disease post-surgery.[2] First-line medical therapy includes somatostatin analogs such as octreotide, lanreotide, and Signifor LAR® (pasireotide intramuscular injection), which target GH secretion. Somavert, a GH receptor antagonist, is recommended for patients with persistent insulin-like growth factor 1 (IGF-1) elevation despite somatostatin analog therapy. Dopamine agonists like cabergoline are considered for mild cases or as adjuncts. Newer agents, including Mycapssa

and investigational drugs like Palsonify, offer promising alternatives with improved convenience and tolerability. The guidelines stress the importance of tailoring therapy based on biochemical response, tumor characteristics, and patient preferences, with increasing interest in biomarker-guided treatment strategies to optimize outcomes. The Endocrine Society Clinical Practice Guidelines for Acromegaly (2014) recommend medical therapy as adjuvant treatment after surgical intervention. 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).[3]

POLICY STATEMENT

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

- **Palsonify™ (paltusotine tablets – Crinetics)**

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 ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i, ii, or iii):
     - **i.** Patient has had an inadequate response to surgery and/or radiotherapy; OR
     - **ii.** Patient is NOT an appropriate candidate for surgery and/or radiotherapy; OR
     - **iii.** Patient is experiencing negative effects due to tumor size (e.g., optic nerve compression); AND
   - **C)** 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: Pre-treatment (baseline) refers to the IGF-1 level prior to the initiation of any somatostatin analog (e.g., Mycapssa [octreotide delayed-release capsules], an octreotide acetate injection product [e.g., Bynfezia Pen, Sandostatin {generics}, 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.

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

CONDITIONS NOT COVERED

- **Palsonify™ (paltusotine tablets – Crinetics)**

is(are) considered not medically necessary for ANY other use(s) including the following; criteria will be updated as new published data are available.

REFERENCES

1. Palsonify™ tablets [prescribing information]. Summit, NJ: San Diego, CA: Crinetics; September 2025.
2. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary*. 2021;24(1):1-13.
3. 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.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	10/08/2025