Drug Therapy Guidelines	Applicable	Signifor®, Signifor® LAR (pasireotide)
Medical Benefit	x	**Effective:** 5/1/18
Pharmacy- Formulary 1	x	**Next Review:** 3/19
Pharmacy- Formulary 2	x	**Date of Origin:** 6/15/13
Pharmacy- Formulary 3/Exclusive	x	**Review Dates:** 3/13, 3/14, 3/15, 3/16, 3/17, 3/18
Pharmacy- Formulary 4/AON	x	

I. Medication Description

Signifor is a somatostatin analogue that exerts its pharmacological activity via binding to somatostatin receptors (SSTRs). Five human somatostatin receptor subtypes are known: SSTR 1, 2, 3, 4, and 5. Signifor binds and activates the SSTRs resulting in inhibition of adrenocorticotropic hormone (ACTH) secretion, which leads to decreased cortisol secretion.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

Signifor LAR is an intramuscular injectable that is administered by a healthcare professional and is therefore considered a medical benefit.

III. Policy

Medical: See Section A
Formulary 1: See Section B
Formulary 2: See Section B
Formulary 3/Exclusive: See Section B
Formulary 4/AON: See Section B

A. Coverage of Signifor LAR is provided when the following criteria are met:
- Medication is prescribed or managed by an endocrinologist **AND**
- Member has a documented diagnosis of acromegaly **AND**
- Member is 18 years of age or older **AND**
- Member is not a candidate for surgery or surgery has not been curative

B. Coverage of Signifor is provided when the following criteria are met:
- Medication is prescribed or managed by an endocrinologist **AND**
- Member has a documented diagnosis of Cushing's disease **AND**
- Member is 18 years of age or older **AND**
- Member is not a candidate for surgery or surgery has not been curative

IV. Quantity Limitations

- Signifor: 60 ampules per month of either 0.3mg/mL, 0.6mg/mL, or 0.9mg/mL strength are provided to allow for twice daily dosing.
- Signifor LAR: 1 kit per month of either 20mg, 40mg, or 60mg strength are provided to allow for dosing every 4 weeks.

V. Coverage Duration

Coverage will be granted for 6 months initially and can be renewed in 12 month intervals.

VI. Coverage Renewal Criteria

Coverage can be renewed based on the following criteria:

- Signifor:
  - Reduction in 24 hour urinary free cortisol (UFC) level after initial 6 months of therapy **OR**
  - Stabilization in 24 hour urinary free cortisol (UFC) level after at least 12 months of therapy **AND**
  - Stabilization of symptoms of disease or in absence of disease progression **AND**
  - Absence of unacceptable toxicity from the drug
- Signifor LAR:
  - Stabilization of symptoms of disease or in absence of disease progression **AND**
  - Absence of unacceptable toxicity from the drug **AND**
  - One of the following:
    - Reduction or stabilization in tumor volume from baseline assessed by MRI after initial 6 months of therapy **OR**
    - Mean growth hormone (GH) level less than 2.5mcg/L and a normal insulin-like growth factor-1 (IGF-1) level after at least 12 months of therapy

VII. Billing/Coding Information

- Signifor LAR
  - J2502: 1 billable unit = 1mg
  - Available in kits containing one 20mg, 40mg, or 60mg powder vial with one prefilled syringe containing diluent for reconstitution, one vial adaptor, and one needle.
- Signifor is available as 0.3mg/mL, 0.6mg/mL, and 0.9mg/mL single dose ampules packed as 1 single ampule, 6 ampules, or 60 ampules per box.
- Pertinent diagnoses: acromegaly and gigantism – E22.0

VIII. Summary of Policy Changes

- 6/15/13: new policy
- 6/15/14: Removal of requirement of initial A1c value to be 8% or less
- 6/15/15: Signifor LAR added to policy as a medical benefit
- 7/1/15: C-code updated; formulary distinctions made
- 1/1/16: drug code updated

- 6/15/16: no policy changes
- 4/5/17: no policy changes
- 5/1/18: no policy changes

IX. References

1. Signifor [pasireotide]. Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. Last revised 3/2015.
2. Colao A, Petersenn S, Newel-Price J, et al. A 12-month phase 3 study of pasireotide in Cushing's disease. NEJM. 2012;366:914-924.
3. Signifor LAR [pasireotide]. Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. Revised 12/2014.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.