Select Octreotide Medications

Policy # 00729
Original Effective Date: 02/08/2021
Current Effective Date: 02/13/2023

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the octreotide products, Bynfezia™‡ and Mycapssa®‡, when their respective patient selection criteria are met to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for the octreotide products, Bynfezia and Mycapssa, will be considered when the requested drug's criteria are met:

- For Bynfezia requests:
  - There is clinical evidence or patient history that suggests the use of GENERIC injectable octreotide will be ineffective or cause an adverse reaction to the patient.
    *(Note: This specific criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*
- For Mycapssa requests:
  - Patient has a diagnosis of acromegaly; AND
  - Patient has responded to and tolerated treatment with octreotide (e.g., Sandostatin®‡, generics) or lanreotide (e.g., Somatuline Depot®‡); AND
  - Patient has tried and failed (e.g., intolerance or inadequate response) GENERIC injectable octreotide unless there is clinical evidence or patient history that suggests the use of GENERIC injectable octreotide will be ineffective or cause an adverse reaction to the patient.
    *(Note: This specific patient criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*

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When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of injectable octreotide (Bynfezia) when there is an absence of clinical evidence or patient history that suggests the use of GENERIC injectable octreotide will be ineffective or cause an adverse reaction to the patient to be **not medically necessary.****

Based on review of available data, the Company considers the use of oral octreotide (Mycapssa) when the patient has NOT tried and failed GENERIC injectable octreotide to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of the octreotide products, Bynfezia and Mycapssa, when the patient selection criteria are not met (EXCEPT those considered **not medically necessary****) to be **investigational.***

Background/Overview

Bynfezia is approved for: 1) Reduction of growth hormone and insulin-like growth factor 1 (IGF-1) [somatomedin C] in adult patients with acromegaly who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses; 2) Treatment of severe diarrhea/flushing episodes associated with metastatic carcinoid tumors in adult patients; and 3) Treatment of profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas) in adult patients. Bynfezia is formulated as a 2,500 mcg/mL injection in a 2.8 mL single-patient use pen. Dosing varies per indication and can be found in the product's package insert.

Mycapssa is approved for long-term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide (e.g., Sandostatin, generics) or lanreotide (Somatuline Depot). Mycapssa is the first oral octreotide product on the market and is available in

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20 mg delayed release capsules. Dosing starts at 20 mg twice daily and can be increased to 80 mg daily. Dosage adjustments can be found in the product's package insert.

Octreotide, which carries indications identical to Bynfezia and Mycapssa, is available in generic form in the following injectable strengths: 50 mcg/mL, 100 mcg/mL, and 500 mcg/mL. These generic formulations offer an equally efficacious and safe, yet economically advantageous, option for therapy.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Bynfezia is approved for: 1) Reduction of growth hormone and insulin-like growth factor 1 (IGF-1) [somatomedin C] in adult patients with acromegaly who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses; 2) Treatment of severe diarrhea/flushing episodes associated with metastatic carcinoid tumors in adult patients; and 3) Treatment of profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas) in adult patients. Mycapssa is approved for long-term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Bynfezia

Bynfezia's safety and efficacy are based on existing studies utilizing injectable octreotide. No studies were conducted versus the currently available generic octreotide products.

Mycapssa

The efficacy of Mycapssa was established in a 9 month, randomized, double-blind, placebo-controlled study that enrolled 56 patients with acromegaly. Patients initiated Mycapssa treatment

twice daily 1 month after their last injection of somatostatin analogs. The starting dose was 40 mg (20 mg in the morning and 20 mg in the evening). Dose increase was allowed during dose titration to 60 mg (40 mg in the morning and 20 mg in the evening) and to a maximal dose of 80 mg daily (40 mg in the morning and 40 mg in the evening) until patients were deemed adequately controlled based on biochemical results and/or clinical judgement. Patients then maintained their target dose until end of treatment.

The primary efficacy endpoint was somatostatin dose-adjusted proportion of patients who maintain their biochemical response, defined as an IGF-1 levels less than or equal to the upper limit of normal at the end of 9 months of treatment. At 9 months, 58% of patients treated with Mycapssa vs. 19% of patients treated with placebo maintained their biochemical response.

Summary
Nothing in these studies demonstrates that that either Bynfezia or Mycapssa are more effective or safer than generic injectable octreotide.

References

1. Bynfezia [package insert]. Sun Pharmaceuticals. Cranbury, New Jersey. Updated January 2020.
2. Mycapssa [package insert]. Chiasma. Scotland, United Kingdom. Updated June 2020.

Policy History

Original Effective Date: 02/08/2021
Current Effective Date: 02/13/2023
01/07/2021 Medical Policy Committee review
01/13/2021 Medical Policy Implementation Committee approval. New policy.
01/06/2022 Medical Policy Committee review
01/12/2022 Medical Policy Implementation Committee approval. No change to coverage.
01/05/2023 Medical Policy Committee review
01/11/2023 Medical Policy Implementation Committee approval. No change to coverage.
Next Scheduled Review Date: 01/2024

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into

standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.