09-J1000-20

Original Effective Date: 04/15/10

Revised: 02/15/25

Subject: Lanreotide (Somatuline® Depot, Lanreotide acetate) Injection

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Lanreotide (Somatuline® Depot) is a somatostatin analogue structurally similar to octreotide (Sandostatin®). Somatostatin analogues were developed to improve upon the duration of action of natural somatostatin, which undergoes rapid proteolytic degradation and has a plasma half-life of only one minute. The predominant pharmacologic effect of lanreotide is a reduction in growth hormone and insulin-like growth factor-1 (IGF-1) concentrations. Lanreotide inhibits basal secretion of several gastric enzymes (e.g., motilin, gastric inhibitory peptide, pancreatic polypeptide) and postprandial secretion of pancreatic polypeptide, gastrin, and cholecystokinin.

Lanreotide is commercially available as a long-acting parenteral preparation. Lanreotide has been used extensively in Europe and several other countries for the treatment of acromegaly and for the symptomatic treatment of neuroendocrine carcinoid tumors. Similar to octreotide, lanreotide is used to minimize the symptoms associated with carcinoid tumors including diarrhea, abdominal pain, and flushing. In addition, lanreotide has exhibited an improvement in progression-free survival as compared to placebo in the treatment of nonfunctioning pancreatic or intestinal neuroendocrine tumors. Lanreotide was approved by the Food and Drug Administration (FDA) for the long-term treatment of acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy in 2007. The FDA approved treatment of patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival in 2014. In 2017, lanreotide was also FDA approved for the treatment of adults with carcinoid syndrome.

POSITION STATEMENT:

I. Initiation of lanreotide (Somatuline Depot, lanreotide acetate) **meets the definition of medical necessity** when **ALL** of the following are met:

1. When used to treat an indication listed in Table 1 below and all of the indication specific criteria are met
2. The member will not receive treatment in combination with octreotide acetate long-acting injection, octreotide delayed-release capsules, or pasireotide long-acting injection
3. If lanreotide acetate (billing code J1932) is requested, the member had an inadequate response or contraindication to lanreotide acetate (billing code J1930) – documentation must be submitted

Table 1

Indication	Specific Criteria
Acromegaly	**ALL** of the following: 1. Lanreotide will be used as long-term therapy for the member's acromegaly 2. **EITHER** of the following are met: a. Member has had an inadequate response to surgery and/or radiotherapy. b. Member is not a candidate for surgery and/or radiotherapy. 3. The dosage will not exceed 120 mg every 4 weeks
Carcinoid Tumors (neuroendocrine tumors of the GI tract, lung, and thymus)	**ALL** of the following: 1. Treatment for **ONE** of the following: a. Metastatic, locoregional advanced, or recurrent disease b. Carcinoid syndrome c. Unresected primary gastrinoma d. Locoregional bronchopulmonary or thymic disease that is unresectable e. Multiple lung nodules or tumorlets and evidence of diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) 2. The dosage will not exceed 120 mg every 4 weeks[a]

Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)	**ALL** of the following: 1. The tumor has **EITHER** of the following features: a. **ALL** of the following: i. Unresectable ii. Well- or moderately-differentiated iii. Locally advanced b. Metastatic 2. The dosage will not exceed 120 mg every 4 weeks[a]
Pancreatic neuroendocrine tumor	**ALL** of the following: 1. Use is for **ONE** of the following: a. To treat symptoms associated with **ONE** of the following: i. Gastrinoma ii. Glucagonoma iii. Vasoactive intestinal peptide tumors (VIPomas) iv. Insulinoma **AND** tumor is somatostatin-receptor positive – documentation must be provided b. For tumor control in member's with unresectable disease, locoregional advanced disease, recurrent, or metastatic disease 2. The dosage will not exceed 120 mg every 4 weeks[a]
Pheochromocytoma or paraganglioma	**ALL** of the following: 1. When used for **ONE** of the following: a. Locally unresectable disease b. Metastatic disease 2. The dosage will not exceed 120 mg every 4 weeks[a]
Well-differentiated neuroendocrine tumors of unknown primary	**ALL** of the following: 1. Treatment of metastatic or unresectable locally advanced disease 2. The dosage will not exceed 120 mg every 4 weeks[a]

Well-differentiated, grade 3 neuroendocrine tumors	**ALL** of the following: 1. Treatment of metastatic or unresectable locally advanced disease 2. The dosage will not exceed 120 mg every 4 weeks[a]
Other FDA-approved or NCCN supported diagnosis (not previously listed above)	When **ALL** of the following are met: 1. **ONE** of the following is met: a. Member is diagnosed with a condition that is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert) **AND** member meets any additional requirements listed in the "Indications and Usage" section of the FDA-approved prescribing information (or package insert) b. Indication **AND** usage is recognized in NCCN Drugs and Biologics Compendium as a Category 1 or 2A recommendation 2. The dose does not exceed the maximum FDA-approved dose[a]

Approval duration: 1 year

II. Continuation of lanreotide (Somatuline Depot, Lanreotide acetate) **meets the definition of medical necessity** for members treated for an indication from Table 1 when the following criteria are met:

1. The member has been previously approved by Florida Blue or another healthplan in the past 2 years, **OR** the member has previously met all indication-specific criteria for coverage
2. Member has experienced a beneficial response to lanreotide
3. If lanreotide acetate (billing code J1932) is requested, the member had an inadequate response or contraindication to lanreotide acetate (billing code J1930) – documentation must be submitted
4. The member will not receive treatment in combination with octreotide acetate long-acting injection, octreotide delayed-release capsules, or pasireotide long-acting injection
5. Dose does not exceed indication-specific dosing in Table 1[a]

[a] The maximum allowable dose can be exceeded if ONE of the following is met:

(1) the dose is supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a for the requested indication, **OR**

(2) the prescriber has provided information in support of therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Approval duration: 1 year

DOSAGE/ADMINISTRATION:

THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.

FDA-approved: lanreotide is indicated for (1) the long-term treatment of acromegaly in patients who have had an inadequate response to or cannot be treated with surgery and/or radiation, (2) the treatment of patients with unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival, and (3) the treatment of adults with carcinoid syndrome. For GEP-NETs and carcinoid syndrome, the recommended dosage is 120 mg every 4 weeks via deep subcutaneous injection. If a patient is already being treated for GEP-NET, do not administer an additional dose for carcinoid syndrome. For acromegaly, the goal of treatment is to reduce growth hormone (GH) and insulin growth factor-1 (IGF-1) levels to normal. Lanreotide should be initiated as a 90 mg deep subcutaneous injection at 4 week intervals for 3 months.

Dosage Adjustments (for acromegaly):

- After three months the dose may be adjusted as outlined in Table 1. Members who are controlled on lanreotide 60- or 90 mg may be considered for an extended dosing interval of 120 mg every 6 to 8 weeks. GH and IGF-1 levels should be obtained 6 weeks after this change in dosing regimen to evaluate persistence of member response.

TABLE 1:

Dosage Adjustment			
GH Level (ng/mL)	**IGF-1**	**Symptoms**	**Dosage Adjustment**
>1 to 2.5	Normal	Controlled	Maintain dose at 90 mg every 4 weeks
>2.5	Elevated	With or without uncontrolled symptoms	Increase dose to 120 mg every 4 weeks
≤1	Normal	Controlled	Decrease dose to 60 mg every 4 weeks

Renal and Hepatic Impairment: Members with moderate or severe renal impairment and moderate or severe hepatic impairment should receive a starting dose of 60 mg for the treatment of acromegaly. For the treatment of GEP-NETs, no adjustment is needed for mild or moderate renal impairment; however, there is insufficient information to recommend a dose for patients with severe renal impairment or with hepatic impairment of any severity. Caution should be exercised when considering members with moderate or severe renal impairment for an extended dosing interval.

Drug Availability: lanreotide is supplied as 60 mg/0.2 mL, 90 mg/0.3 mL, and 120 mg/0.5 mL sterile, single-use, pre-filled syringes. The syringes must be stored in a refrigerator at 2°C to 8°C (36°F to 46°F) and protected from light in its original package.

PRECAUTIONS:

CONTRAINDICATIONS

Hypersensitivity to lanreotide.

WARNINGS

Cholelithiasis and Gallbladder sludge: gallstones may occur due to reduced gallbladder motility; consider periodic monitoring and discontinue if complications are suspected.

Glucose metabolism: lanreotide inhibits secretion of insulin and glucagon; hypoglycemia and hyperglycemia may occur. Glucose monitoring is recommended and anti-diabetic treatment should be adjusted accordingly.

Thyroid Function: slight decreases in thyroid function have been seen during treatment; thyroid function tests are recommended when clinically indicated.

Drug Interactions: lanreotide may reduce the intestinal absorption of concomitant drugs (e.g., cyclosporine).

Cardiac function: bradycardia may occur; use with caution in at-risk patients (e.g., those on medications that cause bradycardia or pre-existing cardiac dysfunction).

Monitoring: Lab tests that may be helpful as biomarkers vary based on tumor type (e.g. Acromegaly measure GH and IGF-1; Carcinoid measure urinary 5-hydroxyindole acetic acid, plasma serotonin, plasma Substance P)

Pregnancy and Lactation: Lanreotide is classified as pregnancy category C and it is unknown is lanreotide is distributed into human milk. Caution should be exercised when administered to women who are breastfeeding.

Steatorrhea and Malabsorption of Dietary Fats: New onset steatorrhea, stool discoloration and loose stools have been reported in patients receiving somatostatin analogs.

BILLING/CODING INFORMATION:

The following codes may be used to describe:

HCPCS Coding:

J1930	Injection, lanreotide, 1 mg
J1932	Injection, lanreotide, (cipla), 1 mg

ICD-10 Diagnosis Codes That Support Medical Necessity:

C74.10 – C74.92	Malignant neoplasm of medulla and unspecified part of adrenal gland
C75.5	Malignant neoplasm of aortic body and other paraganglia
C7A.00	Malignant carcinoid tumor of unspecified site
C7A.010	Malignant carcinoid tumor of the duodenum
C7A.011	Malignant carcinoid tumor of the jejunum

C7A.012	Malignant carcinoid tumor of the ileum
C7A.019	Malignant carcinoid tumor of the small intestine, unspecified portion
C7A.020	Malignant carcinoid tumor of the appendix
C7A.021	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus
C7A.092	Malignant carcinoid tumor of the stomach
C7A.093	Malignant carcinoid tumor of the kidney
C7A.094	Malignant carcinoid tumor of the foregut, unspecified
C7A.095	Malignant carcinoid tumor of the midgut, unspecified
C7A.096	Malignant carcinoid tumor of the hindgut, unspecified
C7A.098	Malignant carcinoid tumors of other sites
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C7B.00 – C7B.04	Secondary carcinoid tumors of distant lymph nodes, liver, bone, peritoneum
C7B.09	Secondary carcinoid tumors of other sites
C7B.8	Other secondary neuroendocrine tumors
C25.0 – C25.9	Malignant neoplasm of pancreas
C37	Malignant neoplasm of thymus
D3A.00	Benign carcinoid tumor of unspecified site
D3A.010 – D3A.012	Benign carcinoid tumor of the duodenum, jejunum, ileum
D3A.019 – D3A.029	Benign carcinoid tumor of the large intestine, unspecified portion, appendix, cecum, ascending colon, transverse colon, descending colon, sigmoid colon, rectum
D3A.090 – D3A.098	Benign carcinoid tumor of the bronchus and lung, thymus, stomach, other
D3A.8	Other benign neuroendocrine tumors
D13.7	Benign neoplasm of endocrine pancreas
D15.0	Benign neoplasm of thymus
D35.2	Benign neoplasm of pituitary gland
D35.3	Benign neoplasm of craniopharyngeal duct
D37.9	Neoplasm of uncertain behavior of digestive organ, unspecified
E16.1	Other hypoglycemia
E16.3	Increased secretion of glucagon
E16.4	Abnormality of secretion of gastrin
E16.8	Other specified disorders of pancreatic internal secretion
E22.0	Acromegaly and pituitary gigantism
E34.00 – E34.09	Carcinoid syndrome

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline revised date.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

DEFINITIONS:

No guideline specific definitions apply.

RELATED GUIDELINES:

Carboplatin (Paraplatin ®) IV, 09-J0000-93
Docetaxel (Taxotere®) IV, 09-J0000-95
Interferon alfa-n3 (Alferon N Injection®), 09-J0000-33
Octreotide Acetate (Sandostatin LAR Depot, Mycapssa) Injection, 09-J0000-90
Pasireotide (Signifor, Signifor LAR) Injection, 09-J1000-94

OTHER:

None.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Coverage Committee on 01/08/25.

GUIDELINE UPDATE INFORMATION:

04/15/10	New Medical Coverage Guideline.
01/15/11	Revision to guideline; consisting of adding ICD-10 codes.
12/15/11	Review and revision to guideline; consisting of updating dosage & administration, precautions and references.
12/15/12	Review and revision to guideline; consisting of revising and reformatting position statement; revising/updating description, dosage/administration, precautions, and reference sections.
06/15/13	Review and revision to guideline; consisting of revising position statement to include quantity limit and approval duration; updating coding and references.
10/15/13	Revision to guideline; consisting of adding QL.
06/15/14	Review and revision to guideline; consisting of revising position statement, updating references and coding.
06/15/15	Review and revision to guideline; consisting of updating the position statement, dosing/administration section, precautions section, and references.
10/01/15	Revision to guideline consisting of coding updates.
11/01/15	Revision: ICD-9 Codes deleted.
06/15/16	Review and revision to guideline consisting of updating the position statement, coding and references.
10/01/16	Update to ICD-10 codes.
06/15/17	Review and revision to guideline consisting of updating the position statement and references.
11/15/17	Revision to guideline consisting of updating the position statement and references.
06/15/18	Review and revision to guideline consisting of updating the position statement, dosing, coding and references.
07/15/19	Review and revision to guideline consisting of updating the position statement, coding and references.

07/15/21	Review and revision to guideline consisting of updating references.
07/15/22	Revision to guideline consisting of updating coding.
08/15/22	Review and revision to guideline consisting of updating the position statement.
10/01/22	Revision: Added HCPCS code J1932 and deleted code J3490.
07/15/23	Review and revision to guideling consisting of updating the references.
10/1/24	ICD-10 coding update.
12/15/24	Review and revision to guideline; consisting of updating the position statement to require step through J1930.
02/15/25	Review and revision to guideling consisting of updating the dosing, warnings, and references.