

# Signifor® LAR (pasireotide) (Intramuscular)

Document Number: IC-0228

Last Review Date: 08/01/2022

Date of Origin: 01/06/2015

Dates Reviewed: 10/2015, 10/2016, 08/2018, 08/2019, 08/2020, 08/2021, 08/2022

## I. Length of Authorization

Coverage is provided for 6 months and may be renewed.

## II. Dosing Limits

### A. Quantity Limit (max daily dose) [NDC Unit]:

- Signifor LAR 10 mg single-use kit: 1 kit per 28 days
- Signifor LAR 20 mg single-use kit: 1 kit per 28 days
- Signifor LAR 30 mg single-use kit: 1 kit per 28 days
- Signifor LAR 40 mg single-use kit: 1 kit per 28 days
- Signifor LAR 60 mg single-use kit: 1 kit per 28 days

### B. Max Units (per dose and over time) [HCPCS Unit]:

#### Acromegaly

- 60 units every 28 days

#### Cushing's disease

- 40 units every 28 days

## III. Initial Approval Criteria <sup>1</sup>

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**
- Confirmation that fasting plasma glucose, hemoglobin A1c, liver enzyme tests, electrocardiogram (ECG), serum magnesium and serum potassium have been evaluated prior to starting; **AND**
- Patients with diabetes mellitus have stable glycemic control and are on optimized anti-diabetic treatment prior to start of therapy; **AND**

### Universal Criteria <sup>1</sup>

- Patient does not have severe hepatic impairment (i.e., Child-Pugh Class C); **AND**
- Patient has not received a long-acting somatostatin analogue (e.g., Octreotide LAR, Lanreotide SR, Lanreotide auto-gel, pasireotide LAR, etc.) within the last 4 weeks; **AND**

Acromegaly † <sup>1,4,5,10</sup>

- Patient diagnosis confirmed by elevated (age-adjusted) or equivocal serum IGF-1 as well as inadequate suppression of growth hormone (GH) after a glucose load; **AND**
- Patient has documented inadequate response to surgery and/or radiotherapy or it is not an option for the patient; **AND**
- Patient's tumor has been visualized on imaging studies (i.e., MRI or CT-scan); **AND**
- Baseline GH and IGF-1 blood levels have been obtained (renewal will require reporting of current levels); **AND**
- Will not be used in combination with oral octreotide or with GH-analogues (e.g., pegvisomant)

#### **Cushing's Disease † Φ<sup>1,9,12,13</sup>**

- Confirmed diagnosis of endogenous Cushing's disease in which the patient's hypercortisolism is not a result of chronic administration of high-dose glucocorticoids or other physiologic conditions; **AND**
- Treatment of patient's disease with pituitary surgery has not been curative **OR** the patient is not a candidate for pituitary surgery; **AND**
- Baseline 24-hour urinary free cortisol (UFC) level, Adrenocorticotrophic hormone (ACTH), late-night salivary cortisol (LNSC), and/or serum cortisol level have been obtained (renewal will require reporting of current levels)

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); Φ Orphan Drug

#### **IV. Renewal Criteria<sup>1</sup>**

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe adrenal insufficiency (evidenced by weakness, fatigue, anorexia, nausea, vomiting, hypotension, hyponatremia or hypoglycemia), uncontrolled hyperglycemia, diabetes, ketoacidosis, bradycardia, QT prolongation, liver test elevations, gallstones (cholelithiasis), pituitary hormone deficiency, etc.; **AND**

#### **Acromegaly<sup>1,4,5,10</sup>**

- Disease response as indicated by an improvement in signs and symptoms compared to baseline; **AND**
  - Reduction of growth hormone (GH) by random testing to < 1.0 mcg/L; **OR**
  - Age-adjusted normalization of serum IGF-1

#### **Cushing's Disease<sup>1,9,12,13</sup>**

- Disease response indicated by reduction in urinary free cortisol (UFC), plasma adrenocorticotrophic hormone (ACTH), late-night salivary cortisol (LNSC), and/or serum cortisol levels from baseline

## V. Dosage/Administration <sup>1</sup>

Indication	Dose
Acromegaly	Initiate at 40 mg by intramuscular injection once every 4 weeks (28 days). <ul style="list-style-type: none"> <li>– Titrate dosage based on treatment response and tolerability up to maximum 60 mg every 4 weeks for patients who have not normalized GH and/or IGF-1 levels after 3 months of treatment with the 40 mg dose.</li> </ul>
Cushing’s disease	Initiate at 10 mg by intramuscular injection once every 4 weeks (28 days). <ul style="list-style-type: none"> <li>– Titrate dosage based on treatment response and tolerability up to maximum 40 mg every 4 weeks for patients who have not normalized 24-hour urinary free cortisol (UFC) after 4 months of treatment with the 10 mg dose.</li> </ul>

## VI. Billing Code/Availability Information

### HCPCS Code:

- J2502 - Injection, pasireotide long acting, 1 mg; 1 billable unit = 1 mg

### NDC:

- Signifor LAR 10 mg single-use kit: 55292-0139-xx
- Signifor LAR 20 mg single-use kit: 55292-0140-xx
- Signifor LAR 30 mg single-use kit: 55292-0141-xx
- Signifor LAR 40 mg single-use kit: 55292-0142-xx
- Signifor LAR 60 mg single-use kit: 55292-0143-xx

## VII. References

1. Signifor [package insert]. Lebanon, NJ; Recordati Rare Diseases, Inc.; June 2020. Accessed July 2022.
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10. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary* 24, 1–13 (2021). <https://doi.org/10.1007/s11102-020-01091-7>
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## Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E22.0	Acromegaly and pituitary gigantism
E34.4	Constitutional tall stature
E24.0	Pituitary-dependent Cushing's disease

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs), and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC