AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Signifor LAR	Page:	1 of 3
Effective Date:	4/21/2025	Last Review Date:	3/26/2025
Applies to:	☒Florida Kids ☒Pennsylvania Kids	☒New Jersey ☒Virginia	☒Maryland ☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Signifor LAR under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

A. Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option
B. Treatment of patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Signifor LAR

Policy/Guideline:

Documentation:

Submission of the following information is necessary to initiate the prior authorization review:

A. Acromegaly:
   1. For initial approval: Laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level and chart notes indicating an inadequate or partial response to surgery or a clinical reason for not having surgery.
   2. For continuation: Laboratory report indicating normal current IGF-1 levels or chart notes indicating that the member's IGF-1 level has decreased or normalized since initiation of therapy.
B. Cushing's disease:
   1. For initial requests, pretreatment cortisol level as measured by one of the following tests:
      a. Urinary free cortisol (UFC) level
      b. Late-night salivary cortisol
      c. 1 mg overnight dexamethasone suppression test (DST)
      d. Longer, low dose DST (2mg per day for 48 hours)

2. For continuation of therapy (if applicable), laboratory report indicating current cortisol level has decreased from baseline as measured by one of the following tests:
   a. Urinary free cortisol (UFC) level
   b. Late-night salivary cortisol
   c. 1 mg overnight dexamethasone suppression test (DST)
   d. Longer, low dose DST (2mg per day for 48 hours)

Criteria for Initial Approval:

A. Acromegaly
Authorization of 12 months may be granted for the treatment of acromegaly when ALL the following criteria are met:
1. Member has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.
2. Member had an inadequate or partial response to surgery OR there is a clinical reason why the member has not had surgery.
3. Member is unable to take Octreotide Acetate Injection followed by Sandostatin Long-Acting Release (LAR) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

B. Cushing's disease
Authorization of 6 months may be granted for members that meet ALL the following criteria:
A. For the treatment of Cushing's disease in members who either have had surgery that was not curative OR for members who are not candidates for surgery
B. The member is unable to take Octreotide Acetate Injection followed by Sandostatin Long-Acting Release (LAR) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Continuation of Therapy:

A. Acromegaly
Authorization of 12 months may be granted for continuation of therapy for acromegaly when the member's IGF-1 level has decreased or normalized since initiation of therapy.

B. Cushing's disease
Authorization of 12 months for continuation of therapy may be granted for members that meet ONE of the following criteria:
1. Lower cortisol levels since the start of therapy per one of the following tests:
   a. Urinary free cortisol (UFC)

b. Late-night salivary cortisol
c. 1 mg overnight dexamethasone suppression test (DST)
d. Longer, low dose DST (2mg per day for 48 hours)

2. Improvement in signs and symptoms of the disease

Approval Duration and Quantity Restrictions:

Approval: Initial and Renewal: 12 months

Quantity Level Limit: 1 kit per 28 days

References:

1. Signifor LAR [package insert]. Bridgewater, NJ: Recordati Rare Diseases Inc.; July 2024.
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3. American Association of Clinical Endocrinologists Acromegaly Guidelines Task Force. Medical guidelines for clinical practice for the diagnosis and treatment of acromegaly – 2011 update. Endocr Pract. 2011;17(suppl 4):1-44.
4. Gadelha MR, Bronstein MD, Brue T, et al. Pasireotide versus continued treatment with octreotide or lanreotide in patients with inadequately controlled acromegaly (PAOLA): a randomized, phase 3 trial. Lancet Diabetes Endocrinol. 2014;2:875-84.
5. Colao A, Bronstein MD, Freda P, et al. Pasireotide versus octreotide in acromegaly: a head-to-head superiority study. J Clin Endocrinol Metab. 2014;99:791–799.
6. Nieman LK, Biller BM, Findling JW, et al. Treatment of Cushing's syndrome: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2015;100(8):2807-31.
7. Fleseriu M, Auchus R, bancos I, et al. Consensus on Diagnosis and Management of Cushing's Disease: A Guideline Update. Lancet Diabetes Endocrinol. 2021; 9: 847-875.