# Signifor® LAR (pasireotide)
## (Intramuscular)

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## 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 billable units (60 mg) every 28 days

Cushing's disease
- 40 billable units (40 mg) every 28 days

## III. Initial Approval Criteria [1]

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 treatment; **AND**
- Patients with diabetes mellitus have stable glycemic control and are on optimized anti-diabetic treatment prior to the start of therapy; **AND**

Universal Criteria [1]

- 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 † [1,4,5,10]**

- Somatuline Depot is the preferred product. Patients must have failed, or have a contraindication, or intolerance to Somatuline Depot prior to consideration of another long-acting somatostatin analogue; **AND**

- 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 [1,9,12,13]**

- 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, Adrenocorticotropic 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 [1]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the 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: uncontrolled hyperglycemia, diabetes, ketoacidosis, bradycardia, QT prolongation, liver test elevations (e.g., alanine aminotransferase [ALT] or aspartate aminotransferase [AST]), cholelithiasis (gallstones) and complications of cholelithiasis (e.g., cholecystitis or cholangitis), pituitary hormone (e.g., thyroid, adrenal, gonadal) deficiencies/severe adrenal insufficiency, etc.; **AND**

**Acromegaly** [1,4,5,10]

- 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** [1,9,12,13]

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

## V. Dosage/Administration [1]

| Indication | Dose |
|---|---|
| Acromegaly | Initiate at 40 mg administered by intramuscular injection once every 4 weeks (28 days).<br>– 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. |
| Cushing's Disease | Initiate at 10 mg administered by intramuscular injection once every 4 weeks (28 days).<br>– 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. |

## 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.; July 2020. Accessed July 2023.

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11. Giustina A, Barkhoudarian G, Beckers A et al. Multidisciplinary management of acromegaly: A consensus. Rev Endocr Metab Disord 21, 667–678 (2020). https://doi.org/10.1007/s11154-020-09588-z
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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 |