UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Bynfezia Pen

Program	Prior Authorization- Bynfezia Pen
Medication	Bynfezia Pen™ (octreotide acetate)
Markets in Scope	Arizona, California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina
Issue Date	11/2020
Pharmacy and Therapeutics Approval Date	11/2020
Effective Date	12/2020

1. Background:

Bynfezia Pen (octreotide acetate) is a somatostatin analogue indicated to reduce blood levels of growth hormone and insulin-like growth factor-I (IGF-1) [somatomedin C] in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation and bromocriptine mesylate at maximally tolerated doses. It is also indicated in adult patients for the treatment of severe diarrhea/flushing episodes associated with metastatic carcinoid tumors in and for the treatment of profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas).[1,2]

The NCCN (National Comprehensive Cancer Network) recommends the use of octreotide acetate for the treatment of meningiomas. The NCCN also recommends octreotide acetate for the treatment of several types of neuroendocrine and adrenal tumors, including neuroendocrine tumors of the pancreas, neuroendocrine tumors of the gastrointestinal tract, lung, and thymus (carcinoid tumors), pheochromocytoma/ paraganglioma and thymomas and thymic carcinomas. The NCCN Palliative Care Guidelines recommend octreotide for the treatment of malignant bowel obstruction.[3]

Clinical evidence supports the use of octreotide acetate for the treatment of chemotherapy and/or radiation-induced diarrhea,3-7 for refractory HIV/AIDS-related diarrhea that does not respond to first-line anti-diarrheal therapy,8-16 and as an adjunct to endoscopic therapy for bleeding gastroesophageal varices associated with liver disease.[17-22]

2. Coverage Criteria:

A. Acromegaly

1. **Initial Authorization**

   a. **Bynfezia Pen** will be approved based on **all** of the following criteria:

      (1) Diagnosis of acromegaly by **one** of the following:

(a) Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis
(b) Elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

-AND-

(2) **One** of the following:

(a) Inadequate response to **one** of the following:
i. Surgery
ii. Radiotherapy
iii. Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

-OR-

(b) Not a candidate for **any** of the following:
i. Surgery
ii. Radiotherapy
iii. Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

-AND-

(3) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Bynfezia Pen** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Bynfezia Pen therapy

Authorization will be issued for 12 months.

B. Meningioma

1. **Initial Authorization**

a. **Bynfezia Pen** will be approved based on **all** of the following criteria:

(1) Diagnosis of meningioma

-AND-

(2) Disease is surgically inaccessible

-AND-

(3) **One** of the following:

(a) Disease is recurrent
(b) Disease is progressive

-AND-

(4) Additional radiation is not possible

-AND-

(5) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Bynfezia Pen** will be approved based upon the following criterion:

(1) Patient does not show evidence of progressive disease while on Bynfezia Pen therapy

Authorization will be issued for 12 months.

C. Neuroendocrine and Adrenal Tumors

1. **Initial Authorization**

a. **Bynfezia Pen** will be approved based on diagnosis of **both** of the following:

(1) **One** of the following:

(a) Neuroendocrine tumors [e.g., carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI tract, lung, thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]

-OR-

(b) **All** of the following:

i. Diagnosis of Pheochromocytoma or Paraganglioma

-AND-

ii. Disease is locally unresectable or distant metastases

-AND-

iii. Disease is somatostatin receptor positive

-AND-

iv. Presence of symptomatic disease

-AND-

(2) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Bynfezia Pen** will be approved based upon **one** of the following criteria:

(1) Patient does not show evidence of progressive disease while on Bynfezia Pen therapy

-OR-

(2) Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to Bynfezia Pen therapy

Authorization will be issued for 12 months.

D. Thymoma or Thymic Carcinoma

1. **Initial Authorization**

a. **Bynfezia Pen** will be approved based on **all** of the following criterion:

(1) Diagnosis of thymoma or thymic carcinoma

-AND-

(2) Used as a second-line therapy for **one** of the following:

(a) Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis.

-OR-

(b) Extrathoracic metastatic disease.

-AND-

(3) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Bynfezia Pen** will be approved based upon the following criterion:

(1) Patient does not show evidence of progressive disease while on Bynfezia Pen therapy

Authorization will be issued for 12 months.

E. Malignant Bowel Obstruction

1. **Initial Authorization**

a. **Bynfezia Pen** will be approved based on **all** of the following criterion:

(1) Diagnosis of malignant bowel obstruction

-AND-

(2) Gut function cannot be maintained

-AND-

(3) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Bynfezia Pen** will be approved based upon the following criterion:

(1) Documentation of positive clinical response to Bynfezia Pen therapy

Authorization will be issued for 12 months.

F. Chemotherapy- and/or Radiation-Induced Diarrhea

1. **Initial Authorization**

a. **Bynfezia Pen** will be approved based on **all** of the following criterion:

(1) Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation

-AND-

(2) **One** of the following:

(a) Presence of Grade 3 or 4 severe diarrhea

-OR-

(b) Patients in palliative or end of life care

-AND-

(3) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Bynfezia Pen** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Bynfezia Pen therapy

Authorization will be issued for 12 months.

G. HIV/AIDS-Related Diarrhea

1. **Initial Authorization**

   a. **Bynfezia Pen** will be approved based on **both** of the following criteria:

      (1) Diagnosis of HIV/AIDS-related diarrhea

      -AND-

      (2) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Bynfezia Pen** will be approved based on the following criterion:

      (1) Documentation of positive clinical response to Bynfezia Pen therapy

      Authorization will be issued for 12 months.

H. Bleeding Gastroesophageal Varices

1. **Initial Authorization**

   a. **Bynfezia Pen** will be approved based on **both** of the following criteria:

      (1) Diagnosis of bleeding gastroesophageal varices associated with liver disease

      -AND-

      (2) Submission of medical records (e.g. chart notes, laboratory values, etc.) documenting a history of failure, intolerance, or contraindication to generic octreotide acetate (e.g., Sandostatin)

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Bynfezia Pen** will be approved based upon the following criterion:

      (1) Documentation of positive clinical response to Bynfezia Pen therapy

      Authorization will be issued for 12 months.

I. NCCN Recommended Regimens

1. Initial Authorization

a. **Bynfezia Pen** will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.

Authorization will be issued for 12 months.

2. Reauthorization

a. **Bynfezia Pen** will be approved based on the following criterion:

(1) Documentation of positive clinical response to Bynfezia therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Bynfezia Pen [package insert]. Cranbury, NJ. Sun Pharmaceutical Industries, Inc. January 2020.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed October 8, 2020.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Palliative Care. Version 2.2019. Available at http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf. Accessed October 8, 2020
4. Benson AB 3rd, Ajani JA, Catalano RB, et al. Recommended guidelines for the treatment of cancer treatment-induced diarrhea. J Clin Oncol. 2004;22(14):2918-26.
5. Yavuz MN, Yavuz AA, Aydin F, et al. The efficacy of octreotide in the therapy of acute radiation-induced diarrhea: a randomized controlled study. In J Radiat Oncol Biol Phys. 2002;54(1):195-202.
6. Fine KD, Schiller LR. American Gastroenterological Association technical review on the evaluation and management of chronic diarrhea. Gastroenterology. 1999;116:1464-1486.

7. Cancer Therapy Evaluation Program. Common Terminology Criteria for Adverse Effects, Version 4.0. National Cancer Institute, Bethesda; National Institutes of Health, U.S. Department of Health and Human Services. June 14, 2010.
8. Cello JP, Grendell JH, Basuk, P, et al. Effect of octreotide on refractory AIDS-associated diarrhea. A prospective, multicenter clinical trial. Annals Internal Medicine. 1991;115(9):705-10.
9. DuPont HL. Guidelines on Acute Infectious Diarrhea in Adults. Am J Gastroenterol. 1997 Nov;92(11):1962-75.
10. Fanning M, Monte M, Sutherland LR, et al. Pilot study of Bynfezia Pen (octreotide) therapy of refractory HIV-associated diarrhea. 1991;36(4):476-80.
11. Garcia Compean D, Ramos Jimenez J, Guzman de la Garza F, et al. Octreotide therapy of large-volume refractory AIDS-associated diarrhea: a randomized controlled trial. AIDS. 1994;8(11):1563-7.
12. Liberti A, Bisogno A, Izzo E. Octreotide treatment in secretory and cryptosporidial diarrhea in patients with acquired immunodeficiency syndrome (AIDS): clinical evaluation. J Chemother. 1992;4(5):303-5.
13. Moroni M, Esposito R, Cernuschi M, et al. Treatment of AIDS-related refractory diarrhoea with octreotide. Digestion. 1993;54 Suppl 1:30-2.
14. New York State Department of Health AIDS Institute. Gastrointestinal complications. October 2006. Located at www.hivguidelines.org. Accessed August 3, 2018.
15. Romeu J, Miro JM, Sirera G, et al. Efficacy of octreotide in the management of chronic diarrhoea in AIDS. AIDS. 1991;5(12):1495.
16. Simon DM, Cello JP, Valenzuela J, et al. Multicenter trial of octreotide in patients with refractory acquired immunodeficiency syndrome-associated diarrhea. Gastroenterology 1995;108(6):1753-60.
17. Gotzsche PC, Hrobjartsson A. Somatostatin analogues for acute bleeding eosophageal varices. Cochrane Database Syst Rev. 2008, Issue 3. Art. No.:CD000193. DOI: 10.1002/14651858.CD000193.pub3.
18. Shah HA, Mumtaz K, Jafri W, et al. Sclerotherapy plus octreotide versus sclerotherapy alone in the management of gastro-eosophageal variceal hemorrhage. J Ayub Med Coll Abbottabad. 2005 Jan-Mar;17(1):10-4.
19. Yücesoy M, Başkol M, Keklik M, et al. Efficacy of five days of subcutaneous octreotide treatment after sclerotherapy in preventing rebleeding from esophageal varices. Turk J Gastroenterol. 2004 Sep;15(3):137-43.
20. Banares R, Albillos A, Rincon D, et al. Endoscopic treatment versus endoscopic plus pharmacologic treatment for acute variceal bleeding: A meta-analysis. Hepatology. 2002;35(3):609-15.
21. Gøtzsche PC1, Hróbjartsson A. Somatostatin analogues for acute bleeding oesophageal varices. Cochrane Database Syst Rev. 2008 Jul 16;(3):CD000193.
22. Garcia-Tsao G, Sanyal AJ, Grace ND, et al. Prevention and management of gastroesophageal varices and variceal hemorrhage in cirrhosis. Am J Gastroenterol. 2007 Sep;102(9):2086-102.
23. Katznelson L, Laws ER Jr, Melmed S, Molitch ME, Murad MH, Utz A, Wass JAH, Endocrine Society. Acromegaly: an Endocrine Society clinical practice guideline. J

Clin Endocrinol Metab. 2014 Nov;99(11):3933-51. Katznelson L, Atkinson JL, Cook DM, et al.; American Association of Clinical Endocrinologists. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of acromegaly--2011 update. Endocr Pract. 2011 Jul-Aug;17 Suppl 4:1-44.

24. Oberg K, Kvols L, Caplin M, et al. Consensus report on the use of somatostatin analogs for the management of neuroendocrine tumors of the gastroenteropancreatic system. Ann Oncol. 2004 Jun;15(6):966-73.

Program	Prior Authorization– Bynfezia Pen (octreotide acetate)
Change Control	
Date	Change
11/2020	New program