UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1340-4
Program	Prior Authorization/Notification
Medication	Mycapssa® (octreotide)
P&T Approval Date	12/2020, 12/20021, 12/2022, 12/2023
Effective Date	3/1/2024

1. Background:

Mycapssa (octreotide) is a somatostatin analog indicated for long-term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide.

2. Coverage Criteria[a]:

A. Acromegaly

1. **Initial Authorization**

a. **Mycapssa** will be approved based **both** of the following criteria:

(1) Diagnosis of acromegaly

-AND-

(2) Patient has responded to and tolerated treatment with **one** of the following somatostatin analogs:

i. Sandostatin (octreotide) or Sandostatin LAR
ii. Somatuline Depot (lanreotide)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mycapssa** will be approved based on of the following criterion:

(1) Documentation of positive clinical response to Mycapssa therapy

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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.
- Medical Necessity may be in place.

4. References:

1. Mycapssa [package insert]. Dublin, Ireland: Amryt Pharmaceuticals, Inc.; March 2022.

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Change Control	
11/2020	New program
12/2021	Annual review with no change to clinical criteria.
12/2022	Annual review with no change to clinical criteria. Added state mandate footnote and updated reference.
12/2023	Annual review with no change to clinical criteria.