Clinical Policy: Lutetium Lu 177 Dotatate (Lutathera)

Reference Number: LA.PHAR.384
Effective Date: 03.16.23
Last Review Date: 05.20.24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Lutetium Lu 177 dotatate (Lutathera®) is a radiolabeled somatostatin analog.

FDA Approved Indication(s)

Lutathera is indicated for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut NETs in adults.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that Lutathera is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Neuroendocrine Tumors (must meet all)**:**

1. Diagnosis of one of the following somatostatin receptor-positive NETs (a, b, or c):
   a. Gastrointestinal tract or pancreas;
   b. Lung or thymus (off-label);
   c. Well-differentiated, grade 3 NET (off-label);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a, b, or c):
   a. Disease is recurrent, metastatic, locally advanced, or unresectable;
   b. For well-differentiated, grade 3 NETs only: Disease has all of the following characteristics (i, ii, and iii):
      i. Metastatic or locally advanced;
      ii. Unresectable;
      iii. Favorable biology (e.g., relatively low Ki-67 [< 55%]);
   c. Member has poorly controlled carcinoid syndrome associated with lung or thymus NET;
5. One of the following (a or b):
   a. Member experienced disease progression while on a somatostatin analog (e.g., octreotide, lanreotide);
   b. Member has a well-differentiated, grade 3 NET;

6. Dose does not exceed 7.4 GBq (200 mCi) every 8 weeks (± 1 week), up to a total of 4 doses.

Approval duration: 36 weeks (no more than 4 total doses)

B. Pheochromocytoma/Paraganglioma (off-label) (must meet all)**:**
1. Diagnosis of a somatostatin receptor-positive pheochromocytoma/paraganglioma;
2. Prescribed by or in consultation with an oncologist;
3. Disease is metastatic or locally unresectable;
4. Dose does not exceed 7.4 GBq (200 mCi) every 8 weeks (± 1 week), up to a total of 4 doses.

Approval duration: 36 weeks (no more than 4 total doses)

C. Other diagnoses/indications (must meet 1 or 2)**:**
a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Lutathera for a covered indication;
2. Member is responding positively to therapy;
3. Member has not received ≥ 4 doses of Lutathera;
4. If request is for a dose increase, new dose does not exceed 7.4 GBq (200 mCi) every 8 weeks (± 1 week), up to a total of 4 doses.

Approval duration: 36 weeks (no more than 4 total doses)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – LA.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CT: computed tomography
FDA: Food and Drug Administration
GEP-NET: gastroenteropancreatic neuroendocrine tumor
mCi: millicurie
NCCN: National Comprehensive Cancer Network

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Somatuline® Depot (lanreotide)	90 – 120 mg SC every 4 weeks	120 mg/month
Sandostatin® LAR Depot (octreotide LAR)*	20 – 30 mg IM once monthly (20 mg may be used for pancreatic NETs)	30 mg/month
Sandostatin® (octreotide)	150 – 250 mcg SC TID	450 mcg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label for the treatment of NETs (octreotide is only FDA-approved for the treatment of symptoms associated with carcinoid tumors) – NET dosing recommendations are per the NCCN guidelines*

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Somatostatin receptor expression can be detected by somatostatin receptor-based imaging, which includes ^{68}Ga-dotatate PET/CT (preferred per the NCCN) and somatostatin receptor scintigraphy.
- Use of Lutathera with somatostatin analogs:
  - Before initiating Lutathera: Long-acting somatostatin analogs (e.g., long-acting octreotide) should be discontinued for at least 4 weeks prior to initiation of Lutathera. Short-acting octreotide can be administered as needed up to 24 hours prior to initiating Lutathera.
  - During Lutathera: Administer long-acting octreotide 30 mg intramuscularly 4 to 24 hours after each Lutathera dose and short-acting octreotide for symptomatic management.
  - Following Lutathera: Continue long-acting octreotide 30 mg intramuscularly every 4 weeks after completing Lutathera until disease progression or for up to 18 months following treatment initiation.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
GEP-NET	7.4 GBq (200 mCi) IV every 8 weeks (± 1 week) for a total of 4 doses	7.4 BGq (200 mCi)/dose (4 doses)
NET of lung or thymus origin, pheochromocytoma, paraganglioma*		

**Off-label – dosing recommendations are per the NCCN guidelines*

VI. Product Availability

Single-dose vial for injection: 370 MBq/mL (10 mCi/mL)

VII. References

1. Lutathera Prescribing Information. Millburn, NJ: Advanced Accelerator Applications USA, Inc.; March 2023. Available at: https://www.lutathera.com. Accessed May 18, 2023.
2. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors. Version 4.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed May 18, 2023.
3. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 18, 2023.
4. Strosberg J, El-Haddad G, Wolin E, et al. Phase 3 trial of ^{177}Lu-dotatate for midgut neuroendocrine tumors. N Engl J Med. 2017; 376(2): 125-135.
5. Brabander T, van der Zwan WA, Teunissen JJM, et al. Long-term efficacy, survival, and safety of [^{177}Lu-DOTA^{0},Tyr^{3}]octreotate in patients with gastroenteropancreatic and bronchial neuroendocrine tumors. Clin Cancer Res. 2017; 1-8.
6. Clinical Pharmacology [database online]. Elsevier, Inc.; 2023. Available at: https://www.clinicalkey.com/pharmacology/.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
A9513	Lutetium Lu 177, dotatate, therapeutic, 1 millicurie (mCi)

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy	02.23	03.16.23
Updated criteria for other diagnoses/indications	06.25.23	10.05.23
Annual review: per NCCN – for NET, added coverage for well-differentiated grade 3 NET and carcinoid syndrome, and for NETs other than the aforementioned two, revised required qualifiers to include recurrent or unresectable; for pheochromocytoma/paraganglioma, revised from “metastatic or locally advanced, and unresectable” to “metastatic or locally unresectable”; revised dosing in criteria, approval duration (from 32 weeks to 36 weeks), and Section V to reflect updated PI, which allows for every 8 week dosing “± 1 week”; updated Appendix D regarding concurrent SSA use per updated PI; references reviewed and updated.	05.20.24	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of Louisiana Healthcare Connections.