UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1340-6
Program	Prior Authorization/Notification
Medication	Mycapssa® (octreotide)*
P&T Approval Date	12/2020, 12/20021, 12/2022, 12/2023, 1/2025, 1/2026
Effective Date	4/1/2026

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 on **both** of the following criteria:

(1) Diagnosis of acromegaly

-AND-

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

i. Octreotide (e.g., Sandostatin, Sandostatin LAR) [Note: Coverage of Sandostatin and Sandostatin LAR may be subject to additional benefit and coverage review requirements]
ii. Lanreotide (e.g., Lanreotide Injection, Somatuline Depot) [Note: Coverage of Lanreotide Injection and Somatuline Depot may be subject to additional benefit and coverage review requirements]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mycapssa*** will be approved based on 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.

*Mycapssa is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

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]. Scotland, UK: MW Encap Ltd.; August 2024.

Program	Prior Authorization/Notification – Mycapssa® (octreotide)
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.
1/2025	Annual review with no change to clinical criteria. Updated reference.
1/2026	Annual review. Added Lanreotide Injection as an example of lanreotide and note that injectable somatostatin analogs may be subject to additional benefit and coverage review requirements. Added exclusion footnote.