# MYCAPSSA (octreotide, oral)

**Diagnosis Considered for Coverage:**
- Acromegaly

**Coverage Criteria:**

**For diagnosis listed above:**
- Being prescribed or recommended by an Endocrinologist, **and**
- Patient has responded to either octreotide (Sandostatin) or Somatuline (lanreotide), **and**
- Dose does not exceed FDA label maximum.

**Coverage Duration:** one year

Effective Date: 1/31/2024



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