Somatuline Depot, lanreotide injection

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or

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seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Acromegaly
   - ❑ Carcinoid syndrome
   - ❑ Well-differentiated grade 3 Neuroendocrine tumors (NETs) with favorable biology, unresectable locally advanced or metastatic NETs (not of gastroenteropancreatic origin) with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)
   - ❑ Neuroendocrine tumors of the gastrointestinal tract (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the thymus (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the lung (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the pancreas (islet cell tumors) (including gastrinomas, glucagonomas, insulinomas, and VIPomas)
   - ❑ Gastroenteropancreatic neuroendocrine tumor (GEP-NETs)
   - ❑ Pheochromocytoma
   - ❑ Paraganglioma
   - ❑ Zollinger-Ellison syndrome
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Acromegaly

3. Is the patient currently on therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #5*
4. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy?
   ACTION REQUIRED: If decreased or normalized, attach chart note(s) or test results indicating normal current IGF-1 levels or indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.
   Indicate below and no further questions.

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❑ Increased
❑ Decreased or normalized
❑ No change

5. How does the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender? ***ACTION REQUIRED: Attach chart note(s) or test results with pretreatment IGF-1 level and reference normal range.***
   ❑ IGF-1 level is **higher** than the laboratory's normal range
   ❑ IGF-1 level is **lower** than the laboratory's normal range
   ❑ IGF-1 level **falls within** the laboratory's normal range

6. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery or radiotherapy and no further questions.*** ❑ Yes ❑ No

7. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating a clinical reason for not having surgery or radiotherapy.***
   ❑ Yes ❑ No

Section B: Carcinoid Syndrome, Pheochromocytoma/Paraganglioma, and Zollinger-Ellison Syndrome

8. Is the patient currently on therapy with the requested medication? ❑ Yes ❑ No *If No, no further questions*

9. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy? ❑ Yes ❑ No *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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