

SOMATOSTATINS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Acromegaly <input type="checkbox"/> Carcinoid syndrome (i.e. flushing and/or diarrhea) <input type="checkbox"/> Flushing and/or diarrhea associated with metastatic carcinoid tumors <input type="checkbox"/> Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) <input type="checkbox"/> Profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist, oncologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Bynfezia requests:

* Please use the table to answer the following questions and **submit chart notes** to support the answers:

Preferred Agent(s)
octreotide (Sandostatin generic equivalent)

5. Has the patient tried and had an inadequate response to the preferred agent? Yes No
6. Was ONE preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
7. Does the patient have an intolerance or hypersensitivity to the preferred agent that is not expected to occur with the requested agent? Yes No
8. Does the patient have an FDA labeled contraindication to the preferred agent that is not expected to occur with the requested agent? Yes No
9. Is ONE preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
10. Is ONE preferred agent not in the best interest of the patient based on medical necessity? Yes No
11. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
12. Is there support for the use of the requested agent over the preferred agent for the requested indication? Yes No
 If yes, please provide supporting information: _____

For the diagnosis of Acromegaly:

13. Will the patient be using the requested agent in combination with Signifor LAR (pasireotide)? Yes No
14. Has the patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by growth hormone and serum IGF-1 that are above the reference ranges? Yes No
 If no, is the patient a candidate for surgical resection? Yes No
 If yes, will the requested agent be used in combination with or following pituitary radiation therapy? Yes No

For Mycapssa requests:

For the diagnosis of Acromegaly:

15. Has the patient responded to AND tolerated treatment with octreotide or lanreotide? Yes No
16. Will the patient be using the requested agent in combination with Signifor LAR (pasireotide) for the requested indication? Yes No

For Palsonify requests:

17. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient's age for the requested indication? Yes No
 If yes, please provide supporting information: _____

For the diagnosis of Acromegaly:

18. Will the patient be using the requested agent in combination with Signifor LAR (pasireotide)? Yes No
19. Has the patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by growth hormone and serum IGF-1 that are above the reference ranges? Yes No
 If no, is the patient a candidate for surgical resection? Yes No
 If yes, will the requested agent be used in combination with or following pituitary radiation therapy? Yes No
20. Has the patient tried and had an inadequate response to another somatostatin analog agent (e.g., Mycapssa, Somavert, Somatuline depot/lanreotide, or Sandostatin LAR)? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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* Please **submit chart notes** to support the answers to the following questions:

21. Has the patient tried and had an inadequate response to cabergoline? Yes No
22. Was cabergoline discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
23. Does the patient have an intolerance or hypersensitivity to cabergoline? Yes No
24. Does the patient have an FDA labeled contraindication to cabergoline? Yes No
25. Is cabergoline expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
26. Is cabergoline not in the best interest of the patient based on medical necessity? Yes No
27. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as cabergoline and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
28. Is there support for the use of the requested agent over cabergoline? Yes No
- If yes, please provide supporting information: _____

* Please use the table to answer the following questions and **submit chart notes** to support the answers:

Preferred Agent(s)
Any generic octreotide agent

29. Has the patient tried and had an inadequate response to ONE preferred agent? Yes No
30. Was ONE preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
31. Does the patient have an intolerance or hypersensitivity to ONE preferred agent? Yes No
32. Does the patient have an FDA labeled contraindication to ALL preferred agents? Yes No
33. Is ONE preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
34. Is ONE preferred agent not in the best interest of the patient based on medical necessity? Yes No
35. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For Somavert requests:

For the diagnosis of Acromegaly:

36. Will the patient be using the requested agent in combination with Signifor LAR (pasireotide)? Yes No
37. Has the patient had an inadequate response to surgical resection or pituitary radiation therapy as indicated by growth hormone and serum IGF-1 that are above the reference ranges? Yes No
- If no, is the patient a candidate for surgical resection? Yes No
- If yes, will the requested agent be used in combination with or following pituitary radiation therapy? Yes No
38. Is the patient currently using a preferred agent for the requested indication? Yes No
- If yes, will the requested agent be used as add on (adjunctive) therapy? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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* Please use the table to answer the following questions and **submit chart notes** to support the answers:

Preferred Agent(s)
lanreotide deep subcutaneous injection (Somatuline Depot generic equivalent)
octreotide gluteal intramuscular injection

39. Has the patient tried and had an inadequate response to ONE of the preferred agents for the requested indication? Yes No
 If yes, has the dose and/or frequency of the preferred agent been increased to the maximally tolerated dose? Yes No
 If no, does the patient have preexisting impaired glucose metabolism? Yes No
40. Was ONE preferred agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
41. Does the patient have an intolerance or hypersensitivity to ONE preferred agent? Yes No
42. Does the patient have an FDA labeled contraindication to ALL preferred agents? Yes No
43. Is ONE preferred agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
44. Is ONE preferred agent not in the best interest of the patient based on medical necessity? Yes No
45. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
46. Is there support for the use of the requested agent over ALL preferred agents for the requested indication? Yes No
 If yes, please provide supporting information: _____

For renewal requests:

47. Has the patient had clinical benefit with the requested agent (e.g., decrease in symptom severity/frequency, reduction in tumor size, normalized IGF-1 and/or growth hormone levels)? Yes No

Please fax or mail this form to:
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 Eagan, MN 55121

TOLL FREE

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BCBSNM: 800.544.1378
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