Lutathera

CareFirstPrior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Lutathera SGM 2513-A – 08/2024.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?

❒ Neuroendocrine tumors of the gastrointestinal (GI) tract (carcinoid tumors), *Continue to 2*

❒ Neuroendocrine tumors of the pancreas, *Continue to 5*

❒ Neuroendocrine tumors of the lung and thymus (carcinoid tumors), *Continue to 6*

❒ Poorly controlled carcinoid syndrome, *Continue to 10*

❒ Pheochromocytoma/paraganglioma, *Continue to 16*

❒ Well-differentiated grade 3 neuroendocrine tumors with favorable biology, *Continue to 18*

❒ Other, please specify. _____, *No Further Questions*

2. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease, *Continue to 3*

❒ Locoregional advanced disease, *Continue to 3*

❒ Distant metastatic disease, *Continue to 3*

❒ Other, please specify. _____, *Continue to 3*

3. Does the patient have either of the following: a) Clinically significant tumor burden or b) disease that has progressed on octreotide long-acting release (LAR) [Sandostatin LAR] or lanreotide (Somatuline Depot)?

❒ Yes, clinically significant tumor burden, *Continue to 4*

❒ Yes, disease progression on octreotide long-acting release (LAR) [Sandostatin LAR] or lanreotide (Somatuline Depot), *Continue to 4*

❒ No/unknown, *Continue to 4*

4. Are the patient's tumors somatostatin receptor-positive? ***ACTION REQUIRED****: If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging*.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ No/unknown, *Continue to 5*

5. What is the clinical setting in which the requested medication will be used?

❒ Symptomatic disease, *Continue to 8*

❒ Clinically significant tumor burden, *Continue to 8*

❒ Progressive recurrent locoregional advanced disease, *Continue to 8*

❒ Distant metastases, *Continue to 8*

❒ Progressive recurrent locoregional advanced disease and distant metastases, *Continue to 8*

❒ Other, please specify. _____, *Continue to 8*

6. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease, *Continue to 8*

❒ Locoregional unresectable disease, *Continue to 8*

❒ Distant metastatic disease, *Continue to 7*

❒ Other, please specify. _____, *Continue to 8*

7. Does the patient have any of the following: a) Clinically significant tumor burden and low grade (typical carcinoid) histology, b) evidence of progression, c) intermediate grade (atypical carcinoid) histology, and/or d) symptomatic disease?

❒ Yes, clinically significant tumor burden and low grade (typical carcinoid) histology, *Continue to 8*

❒ Yes, evidence of disease progression, *Continue to 8*

❒ Yes, intermediate grade (atypical carcinoid) histology, *Continue to 8*

❒ Yes, symptomatic disease, *Continue to 8*

❒ No/unknown, *Continue to 8*

8. Are the patient's tumors somatostatin receptor-positive? ***ACTION REQUIRED***: *If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging*.

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ No/unknown, *, Continue to 9*

9. Has the patient experienced disease progression on octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline Depot)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

10. Does the patient have somatostatin receptor-positive neuroendocrine tumors of the gastrointestinal tract, lung or thymus? ***ACTION REQUIRED***: *If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging*.

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*

❒ No/unknown*, Continue to 11*

11. Has the patient experienced progression on octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline Depot)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. How will the requested medication be used?

❒ In combination with octreotide LAR (Sandostatin LAR), *Continue to 13*

❒ In combination with lanreotide (Somatuline Depot), *Continue to 13*

❒ In combination with telotristat (Xermelo), *Continue to 14*

❒ None of the above, *Continue to 13*

13. Does the patient have persistent symptoms (i.e., flushing, diarrhea)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

14. Does the patient have persistent diarrhea?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. How will the requested medication be used?

❒ In combination with octreotide LAR (Sandostatin LAR), *Continue to 21*

❒ In combination with lanreotide (Somatuline Depot), *Continue to 21*

❒ None of the above, *Continue to 21*

16. What is the clinical setting in which the requested medication will be used?

❒ Locally unresectable disease, *Continue to 17*

❒ Distant metastases, *Continue to 17*

❒ Other, please specify. _____, *Continue to 17*

17. Does the patient have somatostatin receptor-positive pheochromocytoma/paraganglioma? ***ACTION REQUIRED***: *If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.*

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ No/unknown, *Continue to 21*

18. Does the patient's tumor have favorable biology (e.g., relatively low Ki-67 [less than 55%], slow growing, positive somatostatin receptor [SSTR]-based PET imaging)? ***ACTION REQUIRED***: *If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.*

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*

❒ No/unknown, *Continue to 19*

19. What is the clinical setting in which the requested medication will be used?

❒ Unresectable locally advanced disease, *Continue to 20*

❒ Metastatic disease, *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

20. Does the patient have either of the following: a) Clinically significant tumor burden or b) evidence of disease progression?

❒ Yes, clinically significant tumor burden, *Continue to 21*

❒ Yes, evidence of disease progression, *Continue to 21*

❒ No/unknown, *Continue to 21*

21. Will the patient receive more than 4 doses total of the requested drug?

❒ Yes, *No Further Questions*

❒ 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)**