Sandostatin, octreotide acetate, Sandostatin LAR

CareFirst Prior 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

 Sandostatin, Bynfezia, Mycapssa [octreotide] SGM 1734-A – 12/2024.

Criteria Questions:

1. Which product is being requested?

❒ Octreotide acetate injection, *Continue to 3*

❒ Sandostatin injection, *Continue to 3*

❒ Sandostatin LAR Depot, *Continue to 2*

❒ Bynfezia Pen, *Continue to 2*

❒ Mycapssa, *Continue to 4*

2. What is the diagnosis?

❒ Acromegaly, *Continue to 7*

❒ Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion), *Continue to 12*

❒ Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors), *Continue to 12*

❒ Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas), *Continue to 12*

❒ Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), *Continue to 12*

❒ Carcinoid syndrome, *Continue to 12*

❒ Pheochromocytoma, *Continue to 12*

❒ Paraganglioma, *Continue to 12*

❒ Thymomas or thymic carcinoma, *Continue to 12*

❒ AIDS-associated secretory diarrhea, severe, *Continue to 14*

❒ Inoperable bowel obstruction in cancer, *Continue to 18*

❒ Cancer-related diarrhea, *Continue to 22*

❒ Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula), *No further questions*

❒ Acute bleeding of gastroesophageal varices associated with cirrhosis, *No further questions*

❒ Pancreatic fistulas, *Continue to 25*

❒ Pituitary adenoma, *No further questions*

❒ Short bowel syndrome, *Continue to 26*

❒ Zollinger-Ellison syndrome, *Continue to 12*

❒ Other, please specify. _____, *No further questions*

3. What is the diagnosis?

❒ Acromegaly, *Continue to 7*

❒ Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion), *Continue to 12*

❒ Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors), *Continue to 12*

❒ Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas), *Continue to 12*

❒ Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), *Continue to 12*

❒ Carcinoid syndrome, *Continue to 12*

❒ Pheochromocytoma, *Continue to 12*

❒ Paraganglioma, *Continue to 12*

❒ Thymomas or thymic carcinoma, *Continue to 12*

❒ Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy, *No further questions*

❒ AIDS-associated secretory diarrhea, severe, *Continue to 14*

❒ Inoperable bowel obstruction in cancer, *Continue to 18*

❒ Cancer-related diarrhea, *Continue to 22*

❒ Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula), *No further questions*

❒ Acute bleeding of gastroesophageal varices associated with cirrhosis, *No further questions*

❒ Pancreatic fistulas, *Continue to 25*

❒ Pituitary adenoma, *No further questions*

❒ Short bowel syndrome, *Continue to 26*

❒ Zollinger-Ellison syndrome, *Continue to 12*

❒ Other, please specify. _____, *No further questions*

4. What is the diagnosis?

❒ Acromegaly, *Continue to 5*

❒ Other, please specify. _____, *Continue to 5*

5. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 11*
❒ No, *Continue to 6*

6. Has the patient previously responded to and tolerated treatment with octreotide or lanreotide?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

7. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 11*
❒ No, *Continue to 8*

8. 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 laboratory report or chart note(s) with pretreatment IGF-1 level and reference normal range.
❒ IGF-1 level is higher than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*
❒ IGF-1 level is lower than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*
❒ IGF-1 level falls within the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

9. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results indicating an inadequate or partial response to surgery or radiotherapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results indicating a clinical reason for not having surgery or radiotherapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. 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 chart notes indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.

❒ Increased, *No further questions*

❒ Decreased or normalized ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No change, *No further questions*

12. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 13*
❒ No, *No Further Questions*

13. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 17*
❒ No, *Continue to 15*

15. Has the patient tried anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Have the anti-microbial or anti-motility agents become ineffective?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 21*
❒ No, *Continue to 19*

19. Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Does the patient have inoperable bowel obstruction?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Is the patient currently on therapy with the requested medication?
❒ Yes, *Continue to 24*
❒ No, *Continue to 23*

23. Does the patient have grade 3 or greater diarrhea according to National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) indicating grade 3 or 4 cancer-related diarrhea.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Is the requested medication being prescribed for prevention and treatment of pancreatic fistulas following pancreatic surgery?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

26. What is the patient's daily intravenous fluid requirement in liters?
❒ Less than or equal to 3 liters, *No further questions*
❒ Greater than 3 liters, *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)**