Somatuline Depot, lanreotide injection

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? _____

What product is being requested? ❑ lanreotide injection ❑ Somatuline Depot

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

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 patient's diagnosis?

❒ Acromegaly, *Continue to 2*

❒ Carcinoid syndrome, *Continue to 7*

❒ Neuroendocrine tumors (NETs) of the gastrointestinal tract (GI), lung, and thymus (carcinoid tumors), *Continue to 7*

❒ Neuroendocrine tumors (NETs) of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, insulinomas, and VIPomas), *Continue to 7*

❒ Gastroenteropancreatic neuroendocrine tumor (GEP-NETs), *Continue to 7*

❒ Pheochromocytoma, *Continue to 7*

❒ Paraganglioma, *Continue to 7*

❒ Zollinger-Ellison syndrome, *Continue to 7*

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

2. Is the patient currently on therapy with the requested medication?

❒ Yes, *Continue to 6*

❒ No, *Continue to 3*

3. 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 indicating high pretreatment insulin-like growth factor-1 (IGF-1) level.

❒ IGF-1 level is higher than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ IGF-1 level is lower than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ IGF-1 level falls within the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

4. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED***: If Yes, attach chart note(s) indicating an inadequate or partial response to surgery or radiotherapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *No Further Questions*

❒ No, *Continue to 5*

5. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED***: If Yes, attach chart note(s) indicating a clinical reason for not having surgery or radiotherapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. 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 laboratory report indicating normal current IGF-1 levels or chart(s) notes 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*

7. Is the patient currently on therapy with the requested medication?

❒ Yes, *Continue to 8*

❒ No, *No Further Questions*

8. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
❒ 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)**

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