

CAREFIRST COMMERCIAL - NON-RISK - SPC

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group:	<input type="text"/>
Patient DOB:	<input type="text"/>

Physician Information

Physician Name	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Addr.:	<input type="text"/>
City, St, Zip:	<input type="text"/>

Drug Name (select from list of drugs shown)

Bynfezia Pen octreotide acetate Sandostatin Kit LAR Sandostatin Injection Mycapssa

Quantity:	_____	Frequency:	_____	Strength:	_____
Route of Administration:	_____				
Expected Length of Therapy:	_____				
Diagnosis:	_____				
ICD Code:	_____				
Comments:	_____				

Please check the appropriate answer for each applicable question.

1. Which product is being requested?

- | | |
|--|--------------------------|
| Octreotide acetate injection (If checked, go to 3) | <input type="checkbox"/> |
| Sandostatin injection (If checked, go to 3) | <input type="checkbox"/> |
| Sandostatin LAR Depot (If checked, go to 2) | <input type="checkbox"/> |
| Bynfezia Pen (If checked, go to 2) | <input type="checkbox"/> |
| Mycapssa (If checked, go to 4) | <input type="checkbox"/> |

2. What is the diagnosis?

- | | |
|---|--------------------------|
| Acromegaly (If checked, go to 7) | <input type="checkbox"/> |
| Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion) (If checked, go to 12) | <input type="checkbox"/> |
| Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors) (If checked, go to 12) | <input type="checkbox"/> |
| Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas) (If checked, go to 12) | <input type="checkbox"/> |
| Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (If checked, go to 12) | <input type="checkbox"/> |
| Carcinoid syndrome (If checked, go to 12) | <input type="checkbox"/> |
| Pheochromocytoma (If checked, go to 12) | <input type="checkbox"/> |
| Paraganglioma (If checked, go to 12) | <input type="checkbox"/> |

- Thymomas or thymic carcinoma (If checked, go to 12) ☐
- AIDS-associated secretory diarrhea, severe (If checked, go to 14) ☐
- Inoperable bowel obstruction in cancer (If checked, go to 18) ☐
- Cancer-related diarrhea (If checked, go to 22) ☐
- Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula) (If checked, no further questions) ☐
- Acute bleeding of gastroesophageal varices associated with cirrhosis (If checked, no further questions) ☐
- Pancreatic fistulas (If checked, go to 25) ☐
- Pituitary adenoma (If checked, no further questions) ☐
- Short bowel syndrome (If checked, go to 26) ☐
- Zollinger-Ellison syndrome (If checked, go to 12) ☐
- Meningiomas (If checked, go to 27) ☐
- Other, please specify. (If checked, no further questions) _____

3. What is the diagnosis?

- Acromegaly (If checked, go to 7) ☐
- Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion) (If checked, go to 12) ☐
- Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors) (If checked, go to 12) ☐
- Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas) (If checked, go to 12) ☐
- Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (If checked, go to 12) ☐
- Carcinoid syndrome (If checked, go to 12) ☐
- Pheochromocytoma (If checked, go to 12) ☐
- Paraganglioma (If checked, go to 12) ☐
- Thymomas or thymic carcinoma (If checked, go to 12) ☐
- Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy (If checked, no further questions) ☐
- AIDS-associated secretory diarrhea, severe (If checked, go to 14) ☐
- Inoperable bowel obstruction in cancer (If checked, go to 18) ☐
- Cancer-related diarrhea (If checked, go to 22) ☐
- Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula) (If checked, no further questions) ☐
- Acute bleeding of gastroesophageal varices associated with cirrhosis (If checked, no further questions) ☐
- Pancreatic fistulas (If checked, go to 25) ☐
- Pituitary adenoma (If checked, no further questions) ☐
- Short bowel syndrome (If checked, go to 26) ☐
- Zollinger-Ellison syndrome (If checked, go to 12) ☐
- Meningiomas (If checked, go to 27) ☐
- Other, please specify. (If checked, no further questions) _____

4. What is the diagnosis?

- Acromegaly (If checked, go to 5) ☐
- Other, please specify. (If checked, no further questions) _____

- | | | | | | |
|----|--|---|--------------------------|---|--------------------------|
| 5. | Is the patient currently on therapy with the requested medication? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Has the patient previously responded to and tolerated treatment with octreotide or lanreotide? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Is the patient currently on therapy with the requested medication? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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 (If checked, go to 9) ☐
- IGF-1 level is lower than the laboratory's normal range (If checked, no further questions) ☐
- IGF-1 level falls within the laboratory's normal range (If checked, no further questions) ☐
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. Y ☐ N ☐
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. Y ☐ N ☐
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 (If checked, no further questions) ☐
- Decreased or normalized (If checked, no further questions) ☐
- No change (If checked, no further questions) ☐
12. Is the patient currently on therapy with the requested medication? Y ☐ N ☐
13. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? Y ☐ N ☐
14. Is the patient currently on therapy with the requested medication? Y ☐ N ☐
15. Has the patient tried anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine)? Y ☐ N ☐
16. Have the anti-microbial or anti-motility agents become ineffective? Y ☐ N ☐
17. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? Y ☐ N ☐
18. Is the patient currently on therapy with the requested medication? Y ☐ N ☐
19. Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction? Y ☐ N ☐
20. Does the patient have inoperable bowel obstruction? Y ☐ N ☐
21. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? Y ☐ N ☐
22. Is the patient currently on therapy with the requested medication? Y ☐ N ☐
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. Y ☐ N ☐
24. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? Y ☐ N ☐
25. Is the requested medication being prescribed for prevention and treatment of pancreatic fistulas following pancreatic surgery? Y ☐ N ☐
26. What is the patient's daily intravenous fluid requirement in liters?
- Less than or equal to 3 liters (If checked, no further questions) ☐
- Greater than 3 liters (If checked, no further questions) ☐
27. Is the patient currently on therapy with the requested medication? Y ☐ N ☐
28. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? Y ☐ N ☐

29. Will the requested medication be used in combination with everolimus? Y ☐ N ☐

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

Surgically inaccessible recurrent disease (If checked, no further questions) ☐

Surgically inaccessible progressive disease (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.