Somavert

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Acromegaly ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred product for your patient's health plan is Somatuline Depot. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
4. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Somatuline Depot)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes ❑ No
5. Is the patient currently on therapy with Somavert? *If Yes, skip to #9* ❑ Yes ❑ No
6. 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 a laboratory report or chart note(s) with pretreatment IGF-level and reference normal range.***
   ❑ IGF-1 level is **highe**r than the laboratory's normal range
   ❑ IGF-1 level is **lower** than the laboratory's normal range
   ❑ IGF-1 level **falls within** the laboratory's normal range
7. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery or radiotherapy and no further questions.*** ❑ Yes ❑ No
8. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating a clinical reason for not having surgery or radiotherapy.***
   ❑ Yes ❑ No *No further questions.*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

9. 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 notes indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.***
❑ Increased ❑ Decreased or normalized ❑ No change

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)**

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