PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 3/31/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:** _____
Specialty:
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

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) ☐
   - Sandostatin injection (If checked, go to 3) ☐
   - Sandostatin LAR Depot (If checked, go to 2) ☐
   - Bynfezia Pen (If checked, go to 2) ☐
   - Mycapssa (If checked, go to 4) ☐

2. 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) ☐
   - 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) ☐

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) ☐

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** ☐ **N** ☐

6. Has the patient previously responded to and tolerated treatment with octreotide or lanreotide? **Y** ☐ **N** ☐

7. Is the patient currently on therapy with the requested medication? **Y** ☐ **N** ☐

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) ☐

ACTION REQUIRED: Submit supporting documentation

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. ACTION REQUIRED: Submit supporting documentation — **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. ACTION REQUIRED: Submit supporting documentation — **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) ☐

ACTION REQUIRED: Submit supporting documentation

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. ACTION REQUIRED: Submit supporting documentation — **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) ☐

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