BlueCross BlueShield Federal Employee Program

SOMATULINE DEPOT PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Somatuline Depot (lanreotide)

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on Somatuline Depot therapy for at least **2 months** continuously, excluding samples? ***Please select answer below***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's **diagnosis**?

❑**Acromegaly**

i. Has there been an inadequate response or contraindication to surgery or radiotherapy? ❑Yes ❑No

❑**Carcinoid syndrome**

❑**Neuroendocrine tumors (NET)**: Please select the type of tumor below and answer the following question(s):

❑**Adrenal Gland tumors**

i. Does the patient have a diagnosis of non-adrenocorticotropic hormone (non-ACTH) dependent Cushing's syndrome? ❑Yes ❑No

ii. Does the patient have a positive somatostatin scintigraphy? ❑Yes ❑No

❑**Gastrointestinal Tract tumors**

i. Does the patient have distant metastases or unresectable disease? ❑Yes ❑No

❑**Lung tumors (carcinoid tumor)**

i. Does the patient have distant metastases or unresectable disease? ❑Yes ❑No

❑**Pancreatic tumors**

i. Does the patient have distant metastases or unresectable disease? ❑Yes ❑No

ii. Does the patient have a positive somatostatin scintigraphy or hormone related symptoms? ❑Yes ❑No

❑**Poorly Differentiated (High-grade) Tumors / Large or Small Cell Tumors (excluding lung)**

i. Does the patient have distant metastases or unresectable disease? ❑Yes ❑No

ii. Does the patient have a positive somatostatin scintigraphy or hormone related symptoms? ❑Yes ❑No

❑**Thymus tumors (carcinoid tumor)**

i. Does the patient have distant metastases or unresectable disease? ❑Yes ❑No

❑**Other diagnosis *(please specify)*:** _____

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's **diagnosis**?

❑**Acromegaly**

❑**Carcinoid syndrome**

❑**Neuroendocrine tumors (NET)**: Please select where the tumor is located below:

❑**Adrenal Gland** ❑**Gastrointestinal tract** ❑**Lung** ❑**Pancreas** ❑**Thymus**

❑**Poorly Differentiated (high-grade) Tumors / Large or Small Cell Tumors (excluding lung)**

❑**Other diagnosis *(please specify)*:** _____

b. Has the patient experienced any disease progression or unacceptable toxicity? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug prior authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727** Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

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