Prescriber Criteria Form Octreotide 2025 PA Fax 4361-A v1 010125.docx Sandostatin (octreotide acetate injection) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sandostatin (octreotide acetate injection).

Drug Name: Sandostatin (octreotide acetate injection)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of acromegaly? [If no, then skip to question 6.]	Yes ◯	No ◯
2	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient's insulin-like growth factor-1 (IGF-1) level decreased or normalized since initiation of therapy? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a high pre-treatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range? [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient meet any of the following criteria: A) the patient had an inadequate or partial response to surgery or radiotherapy, B) there is a clinical reason for why the patient has not had surgery or radiotherapy? [No further questions.]	Yes ◯	No ◯
6	Is the requested drug prescribed for any of the following: A) treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumor, B) treatment of profuse watery diarrhea associated with a vasoactive intestinal peptide tumor (VIPoma)-secreting	Yes ◯	No ◯

	tumor? [If yes, then no further questions.]		
7	Is the requested drug being prescribed for tumor control of a thymoma or thymic carcinoma?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____