Prescriber Criteria Form

Somatuline Depot 2024 PA Fax 671-A v1 010124.docx
Somatuline Depot (lanreotide), Lanreotide
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 Somatuline Depot.

Drug Name (select from list of drugs shown):

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) 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	Does the patient have a diagnosis of carcinoid syndrome? [If yes, then no further questions.]	Yes	No
7	Is the requested drug being prescribed for the treatment of an unresectable, well or moderately differentiated, locally advanced or metastatic gastroenteropancreatic	Yes	No

	neuroendocrine tumor (GEP-NET)? [If yes, then no further questions.]		
8	Is the requested drug being prescribed for tumor control of an unresected primary gastrinoma? [If yes, then no further questions.]	Yes	No
9	Is the requested drug being prescribed for tumor control of a neuroendocrine tumor of the thymus or lung in a patient with locoregional unresectable, recurrent, or distant metastatic disease? [If yes, then no further questions.]	Yes	No
10	Is the requested drug being prescribed for tumor control of a well-differentiated grade 3 unresectable locally advanced or metastatic neuroendocrine tumor with favorable biology (e.g., relatively low Ki-67 [less than 55%] and positive somatostatin receptor [SSTR]-based positron emission tomography [PET] imaging)? [If yes, then no further questions.]	Yes	No
11	Is the requested drug being prescribed for tumor control of a pheochromocytoma or paraganglioma? [If no, then no further questions.]	Yes	No
12	Is the requested drug being used for either of the following: A) locally unresectable disease, B) distant metastatic disease?	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:**_____