Somatuline Depot, lanreotide injection

HMSA Medicare Advantage - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Somatuline Depot HMSAMED C26500-A – 10.2025.

Criteria Questions:

Continuation

1. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to #2*

❒ No, *Continue to #4*

2. What is the diagnosis?

❒ Acromegaly, *Continue to #3*

❒ Oncology indication, *Continue to #8*

❒ Other, *No Further Questions*

3. Is the patient receiving benefit, defined as decreased or normalized insulin-like factor 1 (IGF-1) level since initiation of therapy? *If 'Yes', laboratory report indicating normal current IGF-1 level or chart notes indicating that IGF-1 level has decreased or normalized since initiation of therapy must be submitted upon request*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initial

4. What is the diagnosis?

❒ Acromegaly, *Continue to #5*

❒ Oncology indication, *Continue to #8*

❒ Other, *No Further Questions*

Acromegaly

5. How does the patient's pretreatment insulin-like growth factor 1 (IGF-1) level compare to the laboratory's reference normal range based on age and/or gender? *Laboratory report indicating high pretreatment IGF-1 level must be submitted upon request*

❒ IGF-1 level is higher than the laboratory's normal range, *No Further Questions*

❒ IGF-1 level is lower than the laboratory's normal range, *Continue to #6*

❒ IGF-1 level falls within the laboratory's normal range, *Continue to #6*

6. Has the patient had an inadequate or partial response to surgery or radiotherapy? *If 'Yes', chart notes indicating an inadequate or partial response to surgery or radiotherapy must be submitted upon request*

❒ Yes, *No Further Questions*

❒ No, *Continue to #7*

7. Is there a clinical reason why the patient has not had surgery or radiotherapy? *If 'Yes', chart notes indicating a clinical reason for not having surgery or radiotherapy must be submitted upon request*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

GLOBAL ONCOLOGY POLICY CRITERIA:

8. Please list or describe all medications in the oncology regimen
❒Single agent, *Continue to #9*
❒Multiple agents, _____*Continue to #9*

9. What is the patient's diagnosis?
_____ *Continue to #10*

10. Is the requested medication/regimen prescribed for an FDA-approved indication, an indication supported by NCCN with a I or IIA recommendation, or an indication supported by the manufacturer's prescribing information?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Does the patient have a contraindication to the use of the requested medication(s) as listed in the medication(s) prescribing information?

❒ Yes, *Continue to #12*

❒ No, *Continue to #12*

12. Was the single agent or entire drug regimen previously authorized by HMSA/CVS for this member?

❒ Yes, *Continue to #13*

❒ No, *No Further Questions*

❒ Unknown, *No Further Questions*

Continuation Criteria
13. Is there evidence to support the patient is benefitting from treatment (e.g.positive clinical response, lack of disease progression)? Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports treatment is beneficial

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512