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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION MYCAPSSA® (octreotide)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 1-year approval:

1. Is Mycapssa being prescribed by or in consultation with an endocrinologist? **AND**
   ☐ Yes ☐ No

2. Is the member 18 years of age or older? **AND**
   ☐ Yes ☐ No

3. Does the member have a confirmed diagnosis of acromegaly? **AND**
   ☐ Yes ☐ No

4. Has the member responded to and tolerated treatment with a somatostatin analogue (e.g., octreotide or lanreotide) for the last 6 months with a stable dose for the last 3 months? **AND**
   ☐ Yes ☐ No

5. Is there prescriber verbal attestation that the member will be monitored for safety parameters (e.g., cholelithiasis and its complications, hypoglycemia or hyperglycemia, thyroid function, cardiac function, vitamin B12 levels)? **AND**
   ☐ Yes ☐ No

6. Is there prescriber verbal attestation that potential drug interactions will be monitored for and dose adjustments of coadministered drug (e.g., cyclosporine, insulin or antidiabetic agents, digoxin, lisinopril, combined oral contraceptives, bromocriptine, beta blockers, calcium channel blockers, drugs metabolized by CYP 450 with a narrow therapeutic index [e.g., quinidine]) **OR** octreotide (e.g., proton pump inhibitors, H2-receptor antagonists, or antacids) will be made as necessary? **AND**
   ☐ Yes ☐ No

7. Is there verbal prescriber attestation that Mycapssa will be withdrawn periodically to evaluate disease activity? **AND**
   ☐ Yes ☐ No

8. Is there confirmation that Mycapssa therapy will be discontinued if IGF-1 levels remain above the upper normal limit after treatment at the maximum recommended dosage (80 mg daily) **OR** if the member cannot tolerate treatment? **AND**
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

9. Is the member unable to administer the injectable formulation (e.g., age-related decline in dexterity, visual impairment) **OR** has a documented requirement for oral therapy?
   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

10. Does the member continue to meet the above criteria? **AND**
    ☐ Yes ☐ No

11. Does the member demonstrate disease response with treatment as defined by stabilization of disease or relevant clinical laboratory parameters (e.g., IGF-1 level normalization, stabilization, or improvement in signs/symptoms)? **AND**
    ☐ Yes ☐ No

12. Is there confirmation that the member has NOT experienced any treatment-restricting adverse effects (e.g., cholelithiasis and its complications, hypoglycemia or hyperglycemia, thyroid function, cardiac function, vitamin B12 levels, intolerable gastrointestinal symptoms)?
    ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.