Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS – FAMILY HEALTH PLAN

Somatostatin Analogs (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Somatostatin Analogs (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

## Drug Name *(please circle)*

Sandostatin Lar Depot  Signifor  Signifor Lar

Somatuline Depot

Other, please specify_____

Quantity _____  Frequency _____  Strength _____

Route of Administration _____  Expected Length of therapy _____

## Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

## Prescribing Physician

Physician Name: _____

Specialty: _____  NPI Number: _____

Physician Fax: _____  Physician Phone: _____

Physician Address: _____  City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N
   [If yes, skip to question 27.]
2. Is the request for Sandostatin LAR? Y N
   [If no, skip to question 5.]
3. Have baseline A1c or fasting glucose, TSH, and EKG been checked? Y N
   Please submit labs or document results and dates:
   _____
   [If no, then no further questions.]

4. Has the patient had a positive response to octreotide immediate release injection for at least 2 weeks? Y N

   [If yes, skip to question 15.]

   [If no, then no further questions.]

5. Is the request for Signifor (but NOT Signifor LAR)? Y N

   [If no, skip to question 10.]

6. Have baseline A1c, fasting plasma glucose, EKG, potassium, magnesium, TSH, and LFTs been checked? Y N
   Please submit labs or document results and dates:
   _____

   [If no, then no further questions.]

7. Does the patient have a diagnosis of Cushing's Syndrome? Y N

   [If no, then no further questions.]

8. Does the patient have persistent disease after pituitary surgery, or is surgery not an option for this patient? Y N

   [If no, then no further questions.]

9. Has the patient had a trial and failure of cabergoline or have ANY of the following contraindications to cabergoline? A) Uncontrolled hypertension, B) hypersensitivity to ergotamines, C) History of cardiac valve disorders, or D) History of pulmonary, pericardial, or retroperitoneal fibrotic disorders. Y N
   If yes, indicate which apply:
   _____

   [If no, then no further questions.]

   [If yes, skip to question 26.]

10. Has the patient had a trial and failure of Sandostatin LAR, or an intolerance to octreotide or Sandostatin LAR? Y N

    [If no, then no further questions.] Y N

11. Is the request for Signifor LAR?

    [If no, skip to question 13.]

12. Have baseline A1c, fasting plasma glucose, EKG, potassium, magnesium, TSH, and LFTs been checked? Y N
    Please submit labs or document results and dates:
    _____

    [If no, then no further questions.]

    [If yes, skip to question 19.]

13. Is the request for Somatuline Depot? Y N

    [If no, then no further questions.]

14. Has a baseline A1c or fasting glucose been checked? Y N
    Please submit labs or document results and dates:
    _____

    [If no, then no further questions.]

15. Does the patient have a diagnosis of carcinoid tumor or VIPomas? Y N

    [If yes, skip to question 18.]

16. Does the patient have a diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)? Y N
    [If no, skip to question 19.]
17. Did the patient have persistent disease after surgical resection, or is the patient not a candidate for surgery? Y N
    [If no, then no further questions.]
18. Is the requested drug prescribed by or in consultation with an oncologist or endocrinologist? Y N
    [If no, then no further questions.]

    [If yes, skip to question 26.]
19. Does the patient have a diagnosis of acromegaly? Y N
    [If no, then no further questions.]
20. Is the requested drug prescribed by or in consultation with an endocrinologist? Y N
    [If no, then no further questions.]
21. Does the patient have persistent disease following pituitary surgery? Y N
    [If yes, skip to question 23.]
22. Is surgical resection not an option for this patient due to ANY of the following? A) Majority of tumor cannot be resected, B) Patient is a poor surgical candidate based on comorbidities, or C) Patient prefers medical treatment over surgery, or refuses surgery. Y N
    [If no, then no further questions.]
23. Does the patient have a baseline IGF-1 level greater than or equal to 2 times the upper limit of normal (ULN) for age? Y N
    [If yes, skip to question 26.]
24. Does the patient have a history of persistently elevated IGF-1 levels while on maximally tolerated doses of cabergoline for at least 6 months? Y N
    [If yes, skip to question 26.]
25. Was the patient unable to tolerate a trial of cabergoline or does the patient have ANY of the following contraindications to cabergoline? A) Uncontrolled hypertension, B) hypersensitivity to ergotamines, C) History of cardiac valve disorders, or D) History of pulmonary, pericardial, or retroperitoneal fibrotic disorders. Y N
    If yes, indicate which apply:
    _____
    [If no, then no further questions.]
26. Is the patient at least 18 years of age? Y N

    [No further questions.]
27. Has the patient had a clinical response and/or symptom improvement since starting medication? Y N
    [If no, then no further questions.]

28. Is the patient's A1c and/or fasting glucose level controlled? Y N
    If no, submit documentation describing treatment plan to improve blood glucose:
    _____
    [If no, then no further questions.]
29. Is this a renewal for Signifor for treatment of Cushing's syndrome? Y N
    [If no, skip to question 33.]
30. Has the patient's cortisol level decreased or normalized since starting Signifor? Y N
    Please submit labs or document result and test date:
    _____
    [If no, then no further questions.]
31. Have LFT's been checked since starting Signifor? Y N
    [If no, then no further questions.]
32. Were LFT's 5 times the upper limit of normal (UNL) or higher? Y N
    Please submit labs or document result and test date:
    _____
    [No further questions.]
33. Does the patient have a diagnosis of acromegaly? Y N
    [If no, skip to question 35.]
34. Has the patient's IGF-1 level decreased or normalized since starting the requested medication? Y N
    Please submit labs or document result and test date:
    _____
    [No further questions.]
35. Does the patient have a diagnosis of carcinoid tumor or VIPomas? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date