REALRx

PRIOR AUTHORIZATION REQUEST FORM
SANDOSTATIN LAR®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Sandostatin® LAR (octreotide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Has the member had a clinical response and tolerance to immediate-release octreotide prior to depot injection use?	☐	☐	**Please provide documentation**
ACROMEGALY			
1. Has the member had an inadequate response or contraindication to surgery or radiation?	☐	☐	**Please provide documentation**
2. Has the member had an inadequate response or contraindication to a dopamine agonist (i.e., bromocriptine, cabergoline)?	☐	☐	**Please provide documentation**
METASTATIC CARCINOID TUMERS			
1. Does the member have severe diarrhea and flushing associated with metastatic carcinoid tumors?	☐	☐	**Please provide documentation**
VASOACTIVE INTESTINAL PEPTIDE TUMOR (VIPoma)			
1. Does the member have profuse watery diarrhea associated with a Vasoactive Intestinal Peptide Tumor (VIPoma)?	☐	☐	**Please provide documentation**

Gastrointestinal Arterio-Venous Malformations (HEYDE'S SYNDROME)			
1. Is the request for gastrointestinal arteriovenous malformations (e.g. Heyde's Syndrome)?	☐	☐	
NEUROENDOCRINE TUMORS			
1. Is the request for neuroendocrine tumors and in accordance with NCCN guidelines?	☐	☐	
REFRACTORY DIARRHEA ASSOCIATED WITH ACUTE GRAFT VERSUS HOST DISEASE OR CHEMOTHERAPY			
1. Is the request for refractory diarrhea associated with acute graft versus host disease or chemotherapy?	☐	☐	
HIGH OUTPUT FISTULAS			
1. Is the request for high output fistulas?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with a clinically significant response to therapy?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM- 066
Origination Date: 01/11/2018
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023