

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

LUTATHERA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

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

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

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: Lutathera® (lutetium Lu 177 dotatate)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescriber an oncologist or physician that specializes in the treatment of GEP-NETs, or in consultation with an oncologist or physician that specializes in treatment of GEP-NETs?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have unresectable, locally advanced, or metastatic disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Did the member's disease progress while on somatostatin analog treatment or molecularly targeted therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Does the member have somatostatin receptor-positive foregut, midgut, and hindgut GEP-NETs on all target lesions that has been confirmed via NETSPOT or Octreoscan?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the tumor been well-differentiated with a Ki-67 index \leq 20%?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide pathology report
8. Does documentation show the member's Karnofsky score?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
9. Will the member discontinue long-acting somatostatin analog therapy for at least 4 weeks prior to initiation?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Will the member discontinue short-acting somatostatin analog therapy for at least 24 hours prior to Lutathera® initiation?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Will Sandostatin LAR® depot be administered intramuscularly 4-24 hours after each Lutathera® dose?	<input type="checkbox"/>	<input type="checkbox"/>	

12. Will Lutathera® be administered under the control of physicians who are qualified by specific training and experience and are approved by an appropriate governmental agency authorized to license the use of radiopharmaceuticals?	<input type="checkbox"/>	<input type="checkbox"/>	
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-CHIP-M004
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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