HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
LUTATHERA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

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: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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)?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
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?	☐	☐	
4. Does the member have unresectable, locally advanced, or metastatic disease?	☐	☐	**Please provide documentation**
5. Did the member's disease progress while on somatostatin analog treatment or molecularly targeted therapy?	☐	☐	**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?	☐	☐	**Please provide documentation**
7. Has the tumor been well-differentiated with a Ki-67 index ≤ 20%?	☐	☐	**Please provide pathology report**
8. Does documentation show the member's Karnofsky score?	☐	☐	**Please provide documentation**
9. Will the member discontinue long-acting somatostatin analog therapy for at least 4 weeks prior to initiation?	☐	☐	
10. Will the member discontinue short-acting somatostatin analog therapy for at least 24 hours prior to Lutathera® initiation?	☐	☐	

11. Will Sandostatin LAR® depot be administered intramuscularly 4-24 hours after each Lutathera® dose?	☐	☐	
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?	☐	☐	

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-M004
Origination Date: 11/28/2018
Reviewed/Revised Date: 06/21/2022
Next Review Date: 06/21/2023
Current Effective Date: 07/01/2022