

PRIOR AUTHORIZATION REQUEST FORM
SANDOSTATIN LAR®

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

If you have prior authorization questions, please call Advantage U for assistance: 888-605-0858

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. Has the member had a clinical response and tolerance to immediate-release octreotide prior to depot injection use?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ACROMEGALY			
2. Has the member had an inadequate response or contraindication to surgery or radiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had an inadequate response or contraindication to a dopamine agonist (i.e., bromocriptine, cabergoline)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
METASTATIC CARCINOID TUMORS			
1. Does the member have severe diarrhea and flushing associated with metastatic carcinoid tumors?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
VASOACTIVE INTESTINAL PEPTIDE TUMOR (VIPoma)			
1. Does the member have profuse watery diarrhea associated with a Vasoactive Intestinal Peptide Tumor (VIPoma)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
Gastrointestinal Arterio-Venous Malformations (HEYDE'S SYNDROME)			
1. Is the request for gastrointestinal arteriovenous malformations (e.g. Heyde's Syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROENDOCRINE TUMORS			
1. Is the request for neuroendocrine tumors and in accordance with NCCN guidelines?	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	
HIGH OUTPUT FISTULAS			
1. Is the request for high output fistulas?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with a clinically significant response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	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:			

Policy PHARM-MA-066
 Origination Date: 01/01/2022
 Reviewed/Revised Date: 09/13/2023
 Next Review Date: 09/13/2024
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