Sandostatin LAR Depot Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277
For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ **Start of treatment:** Start date ____/____/____ ☐ **Continuation of therapy:** Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:	Office Contact Name:			Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Sandostatin LAR**
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

☐ **Acromegaly**
☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery or radiotherapy?
→ ☐ Yes ☐ No Is there a clinical reason why the patient has not had surgery or radiotherapy?
Please indicate how the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compares to the laboratory's reference normal range based on age and/or gender:
☐ IGF-1 level is higher than the laboratory's normal range
☐ IGF-1 level is lower than the laboratory's normal range
☐ IGF-1 level falls within the laboratory's normal range

☐ **Acute bleeding of gastroesophageal varices associated with cirrhosis**

☐ **Bowel obstruction in terminal cancer**
☐ Yes ☐ No Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction?
☐ Yes ☐ No Does the patient have inoperable bowel obstruction?

☐ **Carcinoid syndrome**
Please indicate which clinical setting the requested medication will be used:
☐ Single agent
☐ In combination with telotristat for persistent diarrhea due to poorly controlled carcinoid syndrome
☐ In combination with other systemic therapy options for persistent symptoms such as flushing or diarrhea, or for progressive disease
☐ Other

☐ **Chemotherapy-induced diarrhea**
☐ Yes ☐ No Is the patient receiving treatment with chemotherapy or radiation?
☐ Yes ☐ No Does the patient have grade 3 or greater diarrhea according to the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

☐ **Enterocutaneous fistula (volume depletion from enterocutaneous fistula)**
☐ **Islet cell tumors (e.g., insulinomas or glucagonaomas)**
☐ Yes ☐ No Does the patient have functioning islet cell tumors (e.g., insulinomas or glucagonomas)?
☐ Yes ☐ No Is the medication being prescribed to stabilize blood glucose levels?
☐ **Meningioma, unresectable recurrent or progressive**
☐ **Neuroendocrine tumors of the gastrointestinal tract (carcinoid tumors), locoregional advanced or metastatic**
☐ **Neuroendocrine tumors of the thymus (carcinoid tumors), unresectable or metastatic**
☐ **Neuroendocrine tumors of the lung (carcinoid tumors), unresectable or metastatic**
☐ **Neuroendocrine tumors of the pancreas**
☐ **Pheochromocytoma, locally unresectable or metastatic**
☐ **Paraganglioma, locally unresectable or metastatic**
☐ **Primary gastrinoma, unresected**
☐ **Pancreatic fistulas**
☐ Yes ☐ No Is the requested medication being prescribed for prevention or treatment of pancreatic fistulas following pancreatic surgery?
☐ **Pituitary adenoma**
☐ **Radiation-induced diarrhea**
☐ Yes ☐ No Is the patient receiving treatment with chemotherapy or radiation?
☐ Yes ☐ No Does the patient have grade 3 or greater diarrhea according to the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)?
☐ **Short bowel syndrome**
What is the patient's daily intravenous fluid replacement in liters? _____
☐ **Thymoma or thymic carcinoma**
☐ Yes ☐ No Is the requested drug prescribed as a second-line therapy with or without prednisone?
Which of the following clinical settings is the requested medication being used in?
☐ Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis
☐ Extrathoracic metastatic disease
☐ Other
☐ **Vasoactive intestinal peptide (VIP)-secreting tumors (VIPomas) (management of symptoms related to hormone hypersecretion)**
☐ **Zollinger-Ellison syndrome**
☐ **Other**

For Continuation Requests (clinical documentation required for all requests):
☐ **Acromegaly**
Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
☐ Increase ☐ Decreased or normalized ☐ No change
☐ **AIDS-associated secretory diarrhea, severe**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Bowel obstruction in terminal cancer**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Carcinoid syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Chemotherapy-induced diarrhea or** ☐ **Radiation-induced diarrhea**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Islet cell tumors (e.g., insulinomas or glucagonaomas)**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Vasoactive intestinal peptide (VIP)-secreting tumors (VIPomas) (management of symptoms related to hormone hypersecretion)**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?
☐ **Zollinger-Ellison syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ___/___/_____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.