Somatuline® Depot (lanreotide) 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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

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: ☐ **Somatuline Depot (lanreotide)**
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.

For Initiation Requests (clinical documentation required for all requests):

☐ **Acromegaly**
☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery or radiotherapy?
→ ☐ Yes ☐ No Is the 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 compare 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
☐ IGF-1 level falls within the laboratory's normal range

☐ **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

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

- ☐ **Primary gastrinoma, unresected**
- ☐ **Well-differentiated grade 3 Neuroendocrine tumors (NETs) with favorable biology, unresectable locally advanced or metastatic NETs with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)**
- ☐ **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 (islet cell tumors, including gastrinomas, glucagonomas, insulinomas and VIPomas)**
- ☐ **Gastroenteropancreatic neuroendocrine tumor, unresectable, well or moderately-differentiated, locally advanced or metastatic**
- ☐ **Pheochromocytoma, locally unresectable or metastatic**
- ☐ **Paraganglioma, locally unresectable or metastatic**
- ☐ **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
- ☐ **Carcinoid syndrome**
  ☐ 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.