



**Octreotide acetate injection,  
Sandostatin, Sandostatin LAR Depot  
or Bynfezia Pen  
Medication Precertification Request**

**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

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

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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

**C. PRESCRIBER INFORMATION**

First Name:		Last Name:		<i>(Check one):</i> <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:			City:		State:		ZIP:
Phone:		Fax:		St Lic #:		NPI #:	
DEA #:		UPIN:		Provider E-mail:			
Office Contact Name:				Phone:			
Specialty <i>(Check one):</i> <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____							

**D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION**

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<b>Dispensing Provider/Pharmacy: <i>(Patient selected choice)</i></b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ <b>TIN:</b> _____ <b>PIN:</b> _____	
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**E. PRODUCT INFORMATION**

Request is for:  Octreotide acetate injection  Sandostatin  Sandostatin LAR  Bynfezia Pen  
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

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

**Congenital hyperinsulinism in an infant/persistent hyperinsulinemic hypoglycemia of infancy (PHHI)**  
 Yes  No Is this medication request for Bynfezia Pen or Sandostatin LAR Depot?

**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)?

**Enterocutaneous fistula (volume depletion from enterocutaneous fistula)**

**Islet cell tumors (e.g., insulinomas or glucagonomas)**  
 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?

**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**

**Paranglioma, 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?

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

**Islet cell tumors (e.g., insulinomas or glucagonomas)**

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.