Lutathera

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Neuroendocrine tumors of the gastrointestinal (GI) tract (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the pancreas
   - ❑ Neuroendocrine tumors of the lung and thymus (carcinoid tumors)
   - ❑ Poorly controlled carcinoid syndrome
   - ❑ Pheochromocytoma/paraganglioma
   - ❑ Other
2. What is the ICD-10 code? ____
3. Will the patient receive more than 4 doses total of the requested drug? ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

4. Does the patient have any of the following? ***Indicate ALL that apply.***

❑ Clinically significant tumor burden	❑ Low grade (typical) histology
❑ Distant metastases	❑ Distant metastatic disease
❑ Evidence of progression	❑ Intermediate grade (atypical) histology
❑ Locoregional unresectable disease	❑ Progressive locoregional advanced disease
❑ Symptomatic disease	❑ None of the above

Complete the following section based on the patient's diagnosis, if applicable.

Section A: NETs of GI, Pancreas or Lung/Thymus

5. Are the patient's tumors somatostatin receptor-positive? ***ACTION REQUIRED: If 'Yes', attach documentation supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.*** ❑ Yes ❑ No/unknown

6. Has the patient experienced disease progression on octreotide (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot)? ❑ Yes ❑ No

Section B: Carcinoid Syndrome, Poorly Controlled

7. Does the patient have somatostatin receptor-positive neuroendocrine tumors of the gastrointestinal tract, lung or thymus? ***ACTION REQUIRED: If 'Yes', attach documentation supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.*** ❑ Yes ❑ No

8. Has the patient experienced progression on octreotide (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot)? ❑ Yes ❑ No

9. How will Lutathera be used?
   - ❑ In combination with octreotide LAR (Sandostatin LAR)
   - ❑ In combination with lanreotide (Somatuline Depot)
   - ❑ In combination with telotristat (Xermelo), *skip to 11*
   - ❑ None of the above

10. Does the patient have persistent symptoms (i.e., flushing, diarrhea)? ❑ Yes ❑ No *No further questions*

11. Does the patient have persistent diarrhea? ❑ Yes ❑ No

Section C: Pheochromocytoma/Paraganglioma

12. Does the patient have somatostatin receptor-positive pheochromocytoma/paraganglioma? ***ACTION REQUIRED: If 'Yes', attach documentation supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.*** ❑ Yes ❑ No/unknown

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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