Sandostatin, Bynfezia, Mycapssa (octreotide)
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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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. Which drug is being prescribed?
   ❑ Sandostatin injection ❑ Sandostatin LAR Depot ❑ octreotide acetate injection (generic)
   ❑ Bynfezia Pen ❑ Mycapssa ❑ Other _____

2. What is the diagnosis?
   ❑ Acromegaly
   ❑ Vasoactive intestinal peptide (VIP)-secreting tumors (VIPomas) (management of symptoms related to hormone hypersecretion)
   ❑ 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

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 Sandostatin, Bynfezia, Mycapssa [octreotide] SGM1734-A - 06.2022.

- ❑ 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, and insulinomas)
- ❑ Carcinoid syndrome
- ❑ Pheochromocytoma, unresectable or metastatic
- ❑ Paraganglioma, unresectable or metastatic
- ❑ Thymomas or thymic carcinoma
- ❑ Congenital hyperinsulinism in an infant/persistent hyperinsulinemic hypoglycemia of infancy (PHHI)
- ❑ AIDS-associated secretory diarrhea, severe
- ❑ Inoperable bowel obstruction in terminal cancer
- ❑ Chemotherapy-induced diarrhea
- ❑ Radiation-induced diarrhea
- ❑ Enterocutaneous fistula (Volume depletion from enterocutaneous fistula)
- ❑ Acute bleeding of gastroesophageal varices associated with cirrhosis
- ❑ Pancreatic fistulas
- ❑ Pituitary adenoma
- ❑ Short bowel syndrome
- ❑ Zollinger-Ellison syndrome
- ❑ Other _____

3. What is the ICD-10 code? _____

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

Section A: Acromegaly

4. Is the patient currently on therapy with the requested medication? *If Yes, skip to #9* ❑ Yes ❑ No

5. *If patient is prescribed Mycapssa,* has the patient previously responded to and tolerated treatment with octreotide or lanreotide? ❑ Yes ❑ No

6. How does 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? ***ACTION REQUIRED: Attach a laboratory report or chart note(s) with pretreatment IGF-level and reference normal range***.
   - ❑ 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

7. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery or radiotherapy and no further questions.*** ❑ Yes ❑ No

8. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating a clinical reason for not having surgery or radiotherapy***.
   ❑ Yes ❑ No *No further questions*

9. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy? ***ACTION REQUIRED: If 'decreased or normalized,' attach laboratory report indicating normal current IGF-1 levels or chart notes indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.***
   - ❑ Increased
   - ❑ Decreased or normalized
   - ❑ No change

Section B: Vasoactive Intestinal Peptide (VIP)-Secreting Tumors (VIPomas)

10. Is the patient currently on therapy with the requested medication? ❑ Yes ❑ No *If No, no further questions*.

11. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section C: Carcinoid Syndrome

12. Is the patient currently on therapy with the requested medication? *If Yes, skip to #14* ❑ Yes ❑ No

13. Is the requested medication being prescribed in any of the following clinical settings? ***Indicate below and no further questions.***
    - ❑ As a 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 _____

14. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy? ❑ Yes ❑ No

Section D: Thymomas and Thymic Carcinomas

15. Please indicate if the requested drug will be used with our without prednisone:
    - ❑ The requested drug will be used with prednisone
    - ❑ The requested drug will be used without prednisone

16. Which of the following clinical settings is the requested medication being used in?
    - ❑ Postoperative treatment for patients who cannot tolerate first-line combination regimens after resection
    - ❑ First-line therapy for patients who cannot tolerate first-line combination regimens
    - ❑ Second-line therapy for unresectable or metastatic disease
    - ❑ Other _____

Section E: AIDS-Associated Diarrhea

17. Is the patient currently on therapy with the requested medication? *If Yes, skip to #20* ❑ Yes ❑ No

18. Has the patient tried anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine)? ❑ Yes ❑ No

19. Have the anti-microbial or anti-motility agents become ineffective? ❑ Yes ❑ No *No further questions*

20. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section F: Inoperable Bowel Obstruction in Terminal Cancer

21. Is the patient currently on therapy with the requested medication? *If Yes, skip to #24* ❑ Yes ❑ No

22. Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction? ❑ Yes ❑ No

23. Does the patient have inoperable bowel obstruction? ❑ Yes ❑ No *No further questions*

24. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section G: Chemotherapy- and Radiation-Induced Diarrhea

25. Is the patient currently on therapy with the requested medication? *If Yes, skip to #28* ❑ Yes ❑ No

26. Is the patient receiving treatment with chemotherapy or radiation? ❑ Yes ❑ No

27. Does the patient have grade 3 or greater diarrhea according to National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating grade 3 or 4 diarrhea with current chemotherapy or radiation***.
    ❑ Yes ❑ No *No further questions*

28. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section H: Pancreatic Fistulas

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
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29. Is the requested medication being prescribed for prevention or treatment of pancreatic fistulas following pancreatic surgery? ❑ Yes ❑ No

Section I: Short Bowel Syndrome

30. What is the patient's daily intravenous fluid requirement in liters? _____liters

Section J: Zollinger-Ellison Syndrome

31. Is the patient currently on therapy with the requested medication? ❑ Yes ❑ No *If No, no further questions.*

32. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

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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