

**Sandostatin Injection / Sandostatin LAR Depot
Prior Authorization Request**

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

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 **1-866-814-5506**. 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.

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

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

Additional Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Criteria Questions:

1. Which drug is being prescribed?
 Sandostatin injection Sandostatin LAR Depot
 octreotide acetate injection (generic) Other _____

2. What is the patient's diagnosis?
 Acromegaly
 Neuroendocrine tumors of the gastrointestinal tract (carcinoid tumors), unresectable 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
 Neuroendocrine tumors of the adrenal gland
 Unresectable meningioma
 Thymoma or thymic carcinoma
 Congenital hyperinsulinism in an infant/persistent hyperinsulinemic hypoglycemia of infancy (PHHI)
 Other _____

3. What is the ICD-10 code? _____

Complete the following section if patient's diagnosis is acromegaly.

4. Is the patient currently on therapy with octreotide? Yes No *If No, skip to #6*

5. How has the patient's IGF-1 level (insulin-like growth factor 1) changed since initiation of therapy?
Indicate below and no further questions.
 Increased Decreased or normalized No change

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6. How does the patient's pretreatment IGF-1 level (insulin-like growth factor 1) 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 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?
If Yes, no further questions Yes No
8. Is there a clinical reason why the patient has not had surgery or radiotherapy? 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)