CareFirst
Family of health care plans

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Somatuline 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.

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:** _____

*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. 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
   ❑ Other _____

2. What is the ICD-10 code? _____

Complete the following questions if diagnosis is Acromegaly.

3. Is the patient currently on therapy with Somatuline Depot?   ❑ Yes   ❑ No   *If No, skip to #5*

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

5. 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?
   ❑ 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

6. Has the patient had an inadequate or partial response to surgery or radiotherapy?   ❑ Yes   ❑ No

7. 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)**