2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	**Phone** (10-15 **minutes** process time)	**Fax** (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Somatuline Depot, lanreotide injection

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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*

Exception Criteria Questions:

A. Which product is being requested?
❑ Somatuline Depot *skip to Clinical Criteria Questions* ❑ lanreotide injection

B. Is the product being requested for the treatment of acromegaly?
❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

C. The preferred products for your patient's health plan are Somatuline Depot and Sandostatin LAR. Can the patient's treatment be switched to Somatuline Depot or Sandostatin LAR?
❑ Yes – Somatuline Depot, *skip to Clinical Criteria Questions*
❑ Yes – Sandostatin LAR *Please obtain Form for preferred product and submit for corresponding PA.*

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

❑ No

D. Does the patient have a documented intolerable adverse event to the preferred product (Somatuline Depot)? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s).*** ❑ Yes ❑ No

E. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, please attach supporting chart note(s).*** ❑ Yes ❑ No

F. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Sandostatin LAR)? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s).*** ❑ Yes ❑ No

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Acromegaly
   - ❑ Carcinoid syndrome
   - ❑ Well-differentiated grade 3 Neuroendocrine tumors (NETs) with favorable biology, unresectable locally advanced or metastatic NETs (not of gastroenteropancreatic origin) 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)
   - ❑ Neuroendocrine tumors of the thymus (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the lung (carcinoid tumors)
   - ❑ Neuroendocrine tumors of the pancreas (islet cell tumors) (including gastrinomas, glucagonomas, insulinomas, and VIPomas)
   - ❑ Gastroenteropancreatic neuroendocrine tumor (GEP-NETs)
   - ❑ Pheochromocytoma
   - ❑ Paraganglioma
   - ❑ Zollinger-Ellison syndrome
   - ❑ Other _____

2. What is the ICD-10 code? _____

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

Section A: Acromegaly

3. Is the patient currently on therapy with the requested medication? ❑ 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? ***ACTION REQUIRED: If decreased or normalized, attach chart note(s) or test results indicating normal current IGF-1 levels or indicating that the patient's IGF-1 level has decreased or normalized 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? ***ACTION REQUIRED: Attach chart note(s) or test results with pretreatment IGF-1 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

6. 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

7. 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

Section B: Carcinoid Syndrome, Pheochromocytoma/Paraganglioma, and Zollinger-Ellison Syndrome

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

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

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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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