Updated: 01/2019
PARP Approved: 02/2019

Prior Authorization Criteria

Sandostatin LAR Depot (octreotide acetate)

All requests for Sandostatin LAR Depot (octreotide acetate) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for SandoSTATIN LAR Depot (Octreotide Acetate) all of the following criteria must be met:

- The member is 18 years of age or older
- Prescribed by or in consultation with an Endocrinologist, Oncologist, or Hematologist
- Previous treatment with octreotide (Sandostatin) immediate release was effective and tolerated
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of acromegaly and the following criteria is met:

- Must have an inadequate response to surgery and/or radiation therapy, unless surgery and/or radiotherapy is not an option
- Documentation of **both** of the following:
  - Elevated serum IGF-1 level for member's gender and age range. Laboratory reference range must be provided.
  - Elevated growth hormone (GH) level defined as a GH level ≥1ng/mL following an oral glucose tolerance test (OGTT)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Documentation of ALL of the following:
    - Chart documentation of clinical benefit and tolerance
    - IGF-1 level has decreased or stabilized since initiation of therapy
    - GH level has decreased or stabilized since initiation of therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of metastatic carcinoid tumors and the following criteria is met:

- The member has severe diarrhea and/or flushing episodes
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Member is experiencing a decrease in severity and occurrence of diarrhea and/or flushing
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of vasoactive intestinal peptide tumors (VIPomas) and the following criteria is met:

- The member has profuse watery diarrhea associated with VIP-secreting tumors
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**

    - Member is experiencing a decrease in severity and occurrence of diarrhea and/or flushing
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of gastroenteropancreatic neuroendocrine tumors (GEP-NETs) and the following criteria is met:

- Must have locoregionally advanced and/or metastatic disease
- Documentation of somatostatin receptor-positive lesions confirmed by gallium-68 dotatate PET/CT or somatostatin receptor scintigraphy
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Member continues to meet initial criteria
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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SANDOSTATIN LAR DEPOT (OCTREOTIDE ACETATE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Acromegaly, ICD-10: _____
- Ø Did the member have an inadequate response to surgery and/or radiotherapy? ☐ Yes ☐ No
- Ø Does the member have an elevated IGF-1 level? ☐ Yes, *lab results attached* ☐ No
- Ø Does the member have a growth hormone (GH) level ≥ 1mg/mL following an oral glucose tolerance test? ☐ Yes, *lab results attached* ☐ No

☐ Metastatic Carcinoid Tumors, ICD-10: _____
- Ø Does the member have severe diarrhea and/or flushing? ☐ Yes ☐ No

☐ Vasoactive Intestinal Peptide Tumors (VIPomas), ICD-10: _____
- Ø Does the member have profuse watery diarrhea associated with the VIP-secreting tumors? ☐ Yes ☐ No

☐ Gastroenteropancreatic neuroendrocrine tumour (GEP-NET), ICD-10: _____
- Ø Does the member have locoregionally advanced and/or metastatic disease? ☐ Yes ☐ No
- Ø Are somatostatin receptor-positive lesions present? ☐ Yes, *documentation attached* ☐ No

☐ Other, ICD-10: _____

Was octreotide (Sandostatin) immediate release effective and tolerated? ☐ Yes ☐ No, please explain:

REAUTHORIZATION

For a diagnosis of Acromegaly:
- Ø Has the member experienced clinical benefit and tolerance of the medication? ☐ Yes ☐ No
- Ø Has the IGF-1 level decreased or stabilized since initiation of therapy? ☐ Yes ☐ No
- Ø Has the GH level decreased or stabilized since initiation of therapy? ☐ Yes ☐ No

For a diagnosis of Metastatic Carcinoid Tumors and VIPomas:
- Ø Has the member experienced a decrease in severity and occurrence of diarrhea and/or flushing? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date