Updated: 01/2020
DMMA Approved: 01/2020

Request for Prior Authorization for Sandostatin LAR Depot (octreotide acetate)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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.

Sandostatin LAR Depot Prior Authorization Criteria:

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** when 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 GH level ≥ 1ng/mL following an oral glucose tolerance test (OGTT)
- Documentation of baseline growth hormone (GH) and IGF-I blood levels.
- **Initial Duration of Approval:** 6 months
- **Reathorization 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** when the following criteria is met:

- The member has severe diarrhea and/or flushing episodes (carcinoid syndrome)
- **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)** when 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
- **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.

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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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 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:
Health Options 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:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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: _____
- Did the member have an inadequate response to surgery and/or radiotherapy? ☐ Yes ☐ No
- Does the member have an elevated IGF-1 level? ☐ Yes, *lab results attached* ☐ No
- 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: _____
- Does the member have severe diarrhea and/or flushing? ☐ Yes ☐ No

☐ Vasoactive Intestinal Peptide Tumors (VIPomas), ICD-10: _____

Does the member have profuse watery diarrhea associated with the VIP-secreting tumors? ☐ Yes ☐ No

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

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

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

For a diagnosis of Metastatic Carcinoid Tumors and VIPomas:

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