Updated: 01/2020
DMMA Approved: 01/2020

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

All requests for Somatuline Depot (lanreotide acetate) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Somatuline Depot (lanreotide acetate) Prior Authorization Criteria:

For all requests for Somatuline Depot (lanreotide acetate) all of the following criteria must be met:

- Must be 18 years of age or older
- Must be prescribed by or in consultation with an endocrinologist or oncologist
- 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 had an inadequate response to surgery and/or radiotherapy, 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 demonstrating clinical benefit and tolerance
    - IGF-1 level has decreased or stabilized since initiation of therapy
    - GH level has decreased or normalized since initiation of therapy
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of unresectable, well- or moderately-differentiated, locally advanced or metastatic **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)**:

- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Chart documentation demonstrating clinical benefit and tolerance
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of **Carcinoid Syndrome** when the following criteria is met:

- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Chart documentation demonstrating clinical benefit and tolerance

    - Member is showing a reduction in the frequency of short-acting somatostatin analog rescue therapy
- **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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SOMATULINE DEPOT (LANREOTIDE 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 (if medically please provide a 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: _____
- Has the member had 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

☐ GEP-NET, ICD-10: _____
- Is it unresectable, well- or moderately-differentiated, locally advanced or metastatic? ☐ Yes ☐ No

☐ Carcinoid syndrome, ICD-10: _____

REAUTHORIZATION

Has the member experienced clinical benefit and tolerance with treatment? ☐ Yes ☐ No

For acromegaly:
- Have the member's GH and IGF-1 level decreased or stabilized since initiation of therapy? ☐ Yes ☐ No

For carcinoid syndrome:
- Has there been a reduction in the frequency of short-acting somatostatin analog rescue therapy? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date