HIGHMARK HEALTH OPTIONS

Updated: 04/2025
DMMA Approved: 04/2025

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, the following criteria must be met in addition to the diagnosis specific criteria below:

- 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 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
  - 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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SOMATULINE DEPOT (LANREOTIDE)
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) 325-6251 Mon – Fri 8 am to 7 pm

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:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
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:	ICD Code:

For Acromegaly:

- 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

For GEP-NET:

- Is it unresectable, well- or moderately-differentiated, locally advanced or metastatic? ☐ Yes ☐ No

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