HIGHMARK WHOLECARE

Updated: 06/2026
PARP Approved: 07/2026

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

- 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 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
- **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.

HIGHMARK WHOLECARE

Updated: 06/2026
PARP Approved: 07/2026

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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION	
Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION		
Medication:	Strength:	
Directions:	Quantity:	Refills:
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:	ICD Code:

Was octreotide (Sandostatin) immediate release effective and tolerated? ☐ Yes ☐ No

For Acromegaly:
- Did the member have an inadequate response to surgery and/or radiotherapy? ☐ Yes ☐ No
- Does the member have an elevated IGF-1 level? ☐ Yes ☐ No
- Does the member have a growth hormone (GH) level ≥ 1mg/mL following an oral glucose tolerance test? ☐ Yes ☐ No

For Metastatic Carcinoid Tumors: does the member have severe diarrhea and/or flushing? ☐ Yes ☐ No

For Vasoactive Intestinal Peptide Tumors (VIPomas): does the member have profuse watery diarrhea associated with the VIP-secreting tumors? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION

For 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 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