Updated: 10/2018
PARP Approved: 11/2018

Prior Authorization Criteria

Somatuline Depot (lanreotide acetate)

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.

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** and 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
- Must evaluate baseline growth hormone (GH) and IGF-I blood levels
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria:**
  - 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:** 6 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:** 3 months
- **Reauthorization criteria:**
  - Chart documentation demonstrating clinical benefit and tolerance
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided with a diagnosis of carcinoid syndrome when the following criteria is met:

- **Initial Duration of Approval:** 3 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:** 6 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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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 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 (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
- Is surgery and/or radiotherapy not an option for the member? ☐ Yes ☐ No
- Has the member had baseline growth hormone and IFG-1 blood levels drawn? ☐ Yes ☐ No

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

☐ Carcinoid syndrome, ICD-10: _____

☐ Other: _____ 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