Lutathera

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Neuroendocrine tumors of the gastrointestinal (GI) tract (carcinoid tumors) (If checked, go to 2)
❒ Neuroendocrine tumors of the pancreas (If checked, go to 5)
❒ Neuroendocrine tumors of the lung and thymus (carcinoid tumors) (If checked, go to 6)
❒ Poorly controlled carcinoid syndrome (If checked, go to 10)
❒ Pheochromocytoma/paraganglioma (If checked, go to 16)
❒ Well-differentiated grade 3 neuroendocrine tumors with favorable biology (If checked, go to 18)

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❒ Other, please specify. _____ (If checked, *no further questions*)

2. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease (If checked, go to 3)

❒ Locoregional advanced disease (If checked, go to 3)

❒ Distant metastatic disease (If checked, go to 3)

❒ Other, please specify. _____ (If checked, go to 3)

3. Does the patient have either of the following: a) clinically significant tumor burden, or b) disease that has progressed on octreotide (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot)?

❒ Yes, clinically significant tumor burden (If checked, go to 4)

❒ Yes, disease progression on octreotide or lanreotide (If checked, go to 4)

❒ No/unknown (If checked, go to 4)

4. Are the patient's tumors somatostatin receptor-positive? ACTION REQURED: If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)

❒ No/unknown (If checked, go to 21)

5. What is the clinical setting in which the requested medication will be used?

❒ Symptomatic disease (If checked, go to 8)

❒ Clinically significant tumor burden (If checked, go to 8)

❒ Progressive recurrent locoregional advanced disease (If checked, go to 8)

❒ Distant metastases (If checked, go to 8)

❒ Progressive recurrent locoregional advanced disease and distant metastases (If checked, go to 8)

❒ Other, please specify. _____ (If checked, go to 8)

6. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease (If checked, go to 8)

❒ Locoregional unresectable disease (If checked, go to 8)

❒ Distant metastatic disease (If checked, go to 7)

❒ Other, please specify. _____ (If checked, *no further questions*)

7. Does the patient have any of the following: a) clinically significant tumor burden and low grade (typical carcinoid) histology, b) evidence of progression, c) intermediate grade (atypical carcinoid) histology, and/or d) symptomatic disease?

❒ Yes, clinically significant tumor burden and low grade (typical carcinoid) histology (If checked, go to 8)

❒ Yes, evidence of disease progression (If checked, go to 8)

❒ Yes, intermediate grade (atypical carcinoid) histology (If checked, go to 8)

❒ Yes, symptomatic disease (If checked, go to 8)

❒ No/unknown (If checked, go to 8)

8. Are the patient's tumors somatostatin receptor-positive? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 9)

❒ No/unknown (If checked, go to 9)

9. Has the patient experienced disease progression on octreotide (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

10. Does the patient have somatostatin receptor-positive neuroendocrine tumors of the gastrointestinal tract, lung or thymus? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 11)
❒ No/unknown (If checked, go to 11)

11. Has the patient experienced progression on octreotide (Sandostatin, Sandostatin LAR) or lanreotide (Somatuline Depot)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. How will the requested medication be used?

❒ In combination with octreotide LAR (Sandostatin LAR) (If checked, go to 13)
❒ In combination with lanreotide (Somatuline Depot) (If checked, go to 13)
❒ In combination with telotristat (Xermelo) (If checked, go to 14)
❒ None of the above (If checked, *no further questions*)

13. Does the patient have persistent symptoms (i.e., flushing, diarrhea)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

14. Does the patient have persistent diarrhea?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. How will the requested medication be used?

❒ In combination with octreotide LAR (Sandostatin LAR) (If checked, go to 21)
❒ In combination with lanreotide (Somatuline Depot) (If checked, go to 21)
❒ None of the above (If checked, go to 21)

16. What is the clinical setting in which the requested medication will be used?

❒ Locally unresectable disease (If checked, go to 17)
❒ Distant metastases (If checked, go to 17)
❒ Other, please specify. _____ (If checked, go to 17)

17. Does the patient have somatostatin receptor-positive pheochromocytoma/paraganglioma? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)
❒ No/unknown (If checked, go to 21)

18. Does the patient's tumor have favorable biology (e.g., relatively low Ki-67 [less than 55%], positive somatostatin receptor [SSTR]-based PET imaging)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test

results supporting positive somatostatin receptor status as detected by somatostatin receptor-based imaging.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 19)
❒ No/unknown (If checked, go to 19)

19. What is the clinical setting in which the requested medication will be used?

❒ Unresectable locally advanced disease (If checked, go to 20)
❒ Metastatic disease (If checked, go to 20)
❒ Other, please specify. _____ (If checked, go to 20)

20. Does the patient have either of the following: a) clinically significant tumor burden, or b) evidence of disease progression?

❒ Yes, clinically significant tumor burden (If checked, go to 21)
❒ Yes, evidence of disease progression (If checked, go to 21)
❒ No/unknown (If checked, go to 21)

21. Will the patient receive more than 4 doses total of the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com