Sandostatin, Bynfezia, Mycapssa (octreotide)

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

Section A: Preferred Product- *Complete the following questions if Sandostatin LAR, Bynfezia Pen or Mycapssa is being prescribed for acromegaly.*

1. The preferred product for your patient's health plan is Somatuline Depot. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Somatuline Depot ❑ No - Continue request for Sandostatin LAR
   ❑ No - Continue request for Bynfezia Pen ❑ No - Continue request for Mycapssa

2. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Somatuline Depot)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes ❑ No

Section B: All Requests

1. Which product is being requested?
   ❑ Octreotide acetate injection ❑ Sandostatin injection ❑ Sandostatin LAR Depot
   ❑ Bynfezia Pen ❑ Mycapssa, *skip to #3*

2. What is the diagnosis? *List continues on next page.*
   ❑ Acromegaly, *skip to Section D*
   ❑ Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion), *skip to Section E*
   ❑ Well-differentiated grade 3 neuroendocrine tumors (NETs) with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging), *skip to Section E*

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❑ Neuroendocrine tumors of the gastrointestinal (GI) tract (carcinoid tumors), *skip to Section E*
❑ Neuroendocrine tumors of the thymus (carcinoid tumors), *skip to Section E*
❑ Neuroendocrine tumors of the lung (carcinoid tumors), *skip to Section E*
❑ Neuroendocrine tumors of the pancreas (islet cell tumors, including gastrinomas, glucagonomas, and insulinomas), *skip to Section E*
❑ Gastroenteropancreatic neuroendocrine tumors (GEP-NETs), *skip to Section E*
❑ Carcinoid syndrome, *skip to Section E*
❑ Pheochromocytoma, *skip to Section E*
❑ Paraganglioma, *skip to Section E*
❑ Thymomas or thymic carcinoma, *skip to Section E*
❑ Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy, *no further questions*
❑ AIDS-associated secretory diarrhea, severe, *skip to Section F*
❑ Inoperable bowel obstruction in cancer, *skip to Section G*
❑ Cancer-related diarrhea, *skip to Section H*
❑ Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula), *no further questions*
❑ Acute bleeding of gastroesophageal varices associated with cirrhosis, *no further questions*
❑ Pancreatic fistulas, *skip to Section I*
❑ Pituitary adenoma, *no further questions*
❑ Short bowel syndrome, *skip to Section J*
❑ Zollinger-Ellison syndrome, *skip to Section E*
❑ Other _____

3. What is the diagnosis?
❑ Acromegaly, *continue to Section C*
❑ Other _____

Section C: Acromegaly - Mycapssa Only

1. Is the patient currently on therapy with the requested medication? *If Yes, skip to Section D* ❑ Yes ❑ No

2. Has the patient previously responded to and tolerated treatment with octreotide or lanreotide?
❑ Yes ❑ No *Continue to Section D*

Section D: Acromegaly - All Medications

1. Is the patient currently on therapy with the requested medication? *If Yes, skip to #5* ❑ Yes ❑ No

2. How does the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender? ***ACTION REQUIRED: Attach a laboratory report or chart note(s) with pretreatment IGF-1 level and reference normal range.***
❑ IGF-1 level is higher than the laboratory's normal range
❑ IGF-1 level is lower than the laboratory's normal range
❑ IGF-1 level falls within the laboratory's normal range

3. Has the patient had an inadequate or partial response to surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results indicating an inadequate or partial response to surgery or radiotherapy.***
If Yes, no further questions. ❑ Yes ❑ No

4. Is there a clinical reason why the patient has not had surgery or radiotherapy? ***ACTION REQUIRED: If Yes, attach chart note(s) or test results indicating a clinical reason for not having surgery or radiotherapy.***
❑ Yes ❑ No *No further questions.*

5. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy? ***ACTION REQUIRED: Attach a laboratory report or chart note(s) with pretreatment IGF-1 level and reference normal range.*** ❑ Increased ❑ Decreased or normalized ❑ No change

Section E: NETs, Carcinoid Syndrome, VIPomas, Pheochromocytoma/Paraganglioma, Thymomas/Thymic Carcinomas, Zollinger-Ellison

1. Is the patient currently on therapy with the requested medication? ❑ Yes ❑ No *If No, no further questions.*
2. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section F: AIDS-Associated Diarrhea

1. Is the patient currently on therapy with the requested medication? *If Yes, skip to #4* ❑ Yes ❑ No
2. Has the patient tried anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine)? ❑ Yes ❑ No
3. Have the anti-microbial or anti-motility agents become ineffective? ❑ Yes ❑ No *No further questions.*
4. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section G: Inoperable Bowel Obstruction in Terminal Cancer

1. Is the patient currently on therapy with the requested medication? *If Yes, skip to #4* ❑ Yes ❑ No
2. Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction? ❑ Yes ❑ No
3. Does the patient have inoperable bowel obstruction? ❑ Yes ❑ No *No further questions.*
4. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section H: Cancer-Related Diarrhea

1. Is the patient currently on therapy with the requested medication? *If Yes, skip to #3* ❑ Yes ❑ No
2. Does the patient have grade 3 or greater diarrhea according to National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) indicating grade 3 or 4 cancer-related diarrhea.*** ❑ Yes ❑ No *No further questions.*
3. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy? ❑ Yes ❑ No

Section I: Pancreatic Fistulas

1. Is the requested medication being prescribed for prevention or treatment of pancreatic fistulas following pancreatic surgery? ❑ Yes ❑ No

Section J: Short Bowel Syndrome

1. What is the patient's daily intravenous fluid requirement in liters?
   ❑ Less than or equal to 3 liters
   ❑ Greater than 3 liters

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)**

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