MEDICARE FORM
SANDOSTATIN LAR DEPOT
(octreotide acetate for injectable suspension) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Sandostatin LAR is non-preferred. The preferred product is Somatuline Depot.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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Please indicate: ☐ **Start of treatment:** Start date ____/____/____ ☐ **Continuation of therapy:** Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check one)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Sandostatin LAR Depot**

Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Note: Sandostatin LAR is non-preferred. The preferred product is Somatuline Depot.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure of Somatuline Depot (lanreotide)?
→ When was the member's trial and failure of Somatuline Depot? _____
→ Please describe the nature of the failure of Somatuline Depot _____

☐ Yes ☐ No Has the patient had an adverse reaction to Somatuline Depot (lanreotide)?
→ When was the member's adverse reaction to Somatuline Depot? _____
→ Please describe the nature of the adverse reaction to Somatuline Depot _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Somatuline Depot (lanreotide) when indicated for the patient's diagnosis.

_____

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

For all requests (clinical documentation required):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in and alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____

☐ Respiratory: _____

☐ Renal: _____

☐ Other: _____

For Initiation Requests (clinical documentation required):

☐ **Acromegaly**

☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery or radiotherapy?

→ ☐ Yes ☐ No Is there a clinical reason why the patient has not had surgery or radiotherapy?

Please indicate how the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compares to the laboratory's reference normal range based on age and/or gender:

☐ 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

☐ Yes ☐ No Has the patient responded to and tolerated short-acting subcutaneous octreotide acetate?

☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?

☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Acute bleeding of gastroesophageal varices associated with cirrhosis**

☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?

☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?

☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **AIDS-associated secretory diarrhea, severe**

☐ Yes ☐ No Has the patient tried anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine)?

☐ Yes ☐ No Have the anti-microbial or anti-motility agents become ineffective?

☐ **Inoperable bowel obstruction in cancer**

☐ Yes ☐ No Is the requested medication being prescribed to manage gastrointestinal symptoms (e.g., nausea, pain, vomiting) from bowel obstruction?

☐ Yes ☐ No Does the patient have inoperable bowel obstruction?

☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?

☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?

☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Chemotherapy-induced diarrhea (CID)**

☐ Yes ☐ No Does the patient have grade 3 or greater diarrhea according to the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE)?

☐ Yes ☐ No Have oral antidiarrheal medications, such as loperamide, become ineffective?

☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?

☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?

☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Malignant Carcinoid syndrome**

☐ Yes ☐ No Will the requested medication be used for symptomatic treatment of severe diarrhea and flushing associated with malignant carcinoid syndrome?

☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?

☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?

☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy**

☐ Yes ☐ No Is this medication request for Sandostatin LAR Depot?

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G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

☐ **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula)**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas)**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Pheochromocytoma & Paraganglioma**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Sulfa urea-induced hypoglycemia**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Pancreatic fistulas**
- ☐ Yes ☐ No Is the requested medication being prescribed for prevention and treatment of pancreatic fistulas following pancreatic surgery?

☐ **Pituitary adenoma**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Short bowel syndrome**
What is the patient's daily intravenous fluid requirement in liters? _____

☐ **Thymoma or thymic carcinoma**
What is the place in therapy in which the requested drug will be used? (First-line therapy, Second-line therapy, Other)? _____
- ☐ Yes ☐ No Has disease progression occurred with first-line therapy?
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion)**
- ☐ Yes ☐ No Will the requested medication be used for symptomatic treatment of profuse watery diarrhea associated with VIP-secreting tumors?
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Zollinger-Ellison syndrome**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Meningiomas**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

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G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests *continued* (clinical documentation required):

☐ **Merkel cell carcinoma**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- What is the clinical setting in which the requested drug will be used? (Metastatic disease, Other) _____
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No The patient has contraindication to anti-PD-L1 or anti-PD-1 therapy?
- ☐ Yes ☐ No The patient has disease progression while on anti-PD-L1 or anti-PD-1 therapy?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

☐ **Other**
- ☐ Yes ☐ No Has initial treatment with short-acting, subcutaneous octreotide acetate been effective and tolerated?
- ☐ Yes ☐ No Will the requested medication be given more frequently than generally accepted by peers?
- ☐ Yes ☐ No Does documentation justify the reason for additional services? Action Required: If 'Yes', documentation must be submitted upon request.

For Continuation Requests (clinical documentation required):

☐ **Acromegaly only:**
Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
☐ Increased ☐ Decreased or normalized ☐ No change

☐ **AIDS-associated secretory diarrhea, severe**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Inoperable bowel obstruction in cancer**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Cancer-related diarrhea**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Carcinoid syndrome**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Neuroendocrine tumors of the gastrointestinal (GI) tract, lung, and thymus (carcinoid tumors)** ☐ **Neuroendocrine tumors of the pancreas (islet cell tumors), including gastrinomas, glucagonomas, and insulinomas)** ☐ **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Pheochromocytoma/paraganglioma**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Thymomas/thymic carcinomas**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion)**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Zollinger-Ellison syndrome**
- ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.