Endocrine and Metabolic: Somatostatic Agents – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   - If yes, is there documentation demonstrating disease stability or a positive clinical response (e.g., normalization of serum IGF-1, normalization of growth hormone, adenoma shrinkage, improvement of flushing, improvement of diarrhea, reduction in tumor volume, decrease in urine free cortisol)?
     ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:

☐ Endocrinologist ☐ Oncologist ☐ Other. Specify:

3. Will this medication be used in combination with another somatostatic agent (e.g. lanreotide, octretide)?

☐ Yes ☐ No

4. Indicate patient's diagnosis and answer the associated questions:
   ☐ Acromegaly
   - Is provider able to attest that the patient is not a candidate for surgery to treat Acromegaly?

   ☐ Yes ☐ No
   - If request is for Mycapssa, provide the following:
     - Has documentation been included demonstrating response and tolerance to treatment with octreotide or lanreotide? ☐ Yes ☐ No
     - Explain why the patient is unable to use injectable octreotide or lanreotide:

   ☐ Carcinoid syndrome
   - Is patient experiencing symptoms related to carcinoid syndrome (e.g., diarrhea, flushing)?
     ☐ Yes ☐ No

   ☐ Cushing's Syndrome
   - Is provider able to attest that the patient has failed or is not a candidate for surgery to treat Cushing's Syndrome? ☐ Yes ☐ No

   ☐ Severe or persistent diarrhea due to chemotherapy
   - Does the patient have a history of failure, contraindication, or intolerance to loperamide?
     ☐ Yes ☐ No

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☐ Vasoactive intestinal peptide-secreting tumor (VIPoma)
- Is the request for the management of diarrhea due to VIPoma? ☐ Yes ☐ No

☐ Gastroenteropancreatic neuroendocrine tumor
- Has patient been diagnosed with gastroenteropancreatic neuroendocrine tumor that is unresectable, well- or moderately-differentiated, locally advanced or metastatic? ☐ Yes ☐ No

☐ Other. Specify:

Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request

Prescriber signature	Prescriber specialty	Date