Prescriber Criteria Form Octreotide 2024 PA Fax 4361-A v1 010124.docx Sandostatin (octreotide acetate injection), octreotide acetate injection Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714.** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Octreotide.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of acromegaly? [If no, then skip to question 6.]	Yes	No
2	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 4.]	Yes	No
3	Has the patient's insulin-like growth factor-1 (IGF-1) level decreased or normalized since initiation of therapy? [No further questions.]	Yes	No
4	Does the patient have a high pre-treatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range? [If no, then no further questions.]	Yes	No
5	Does the patient meet any of the following criteria: A) the patient had an inadequate or partial response to surgery or radiotherapy, B) there is a clinical reason for why the patient has not had surgery or radiotherapy? [No further questions.]	Yes	No
6	Is the requested drug prescribed for any of the following: A) symptomatic treatment of a metastatic carcinoid tumor to suppress or inhibit severe diarrhea or flushing episodes, B) treatment of profuse watery diarrhea associated with a vasoactive intestinal peptide (VIP)-	Yes	No

	secreting tumor? [If yes, then no further questions.]		
7	Is the requested drug being prescribed for tumor control of a thymoma or thymic carcinoma? [If no, then no further questions.]	Yes	No
8	Is the requested drug being used for any of the following: A) locally advanced or metastatic disease, B) postoperatively following tumor resection?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____