Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Octreotide (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Octreotide (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

octreotide

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 22.]

2. Does the member have a diagnosis of acromegaly? Y N

   [If no, skip to question 9.]

3. Does the member have persistent disease following radiotherapy or pituitary surgery? Y N

   [If yes, skip to question 5.]

4. Is surgical resection not an option for this member due to ONE of the following? A) Majority of tumor cannot be resected, B) Member is a poor surgical candidate based on comorbidities, or C) Member prefers medical treatment over surgery, or refuses surgery. Y N

   [If no, then no further questions.]

5. Does the member have a baseline IGF-1 level greater than or equal to 2 times the upper limit of normal (ULN) for age? Y N

   [If yes, then skip to question 8.]

6. Does the member have a history of persistently elevated IGF-1 levels while on maximally tolerated doses of cabergoline for at least 6 months? Y N

   Provide IGF-1 level and date when member was on cabergoline:

   _____

   [If yes, then skip to question 8.]

7. Was the member unable to tolerate a trial of cabergoline or does the member have ANY of the following contraindications to cabergoline? A) Uncontrolled hypertension, B) hypersensitivity to ergotamines, C) History of cardiac valve disorders, or D) History of pulmonary, pericardial, or retroperitoneal fibrotic disorders. Y N

   If yes, indicate which apply:

   _____

   [If no, then no further questions.]

8. Is octreotide prescribed by or in consultation with an endocrinologist? Y N

   [If no, then no further questions.]

   [If yes, skip to question 21.]

9. Does the member have a diagnosis of carcinoid tumor or VIPomas? Y N

   [If no, skip to question 12.]

10. Will octreotide be prescribed to reduce the frequency of short-acting somatostatin analog rescue therapy? Y N

    [If no, no further questions.]

11. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

[If yes, skip to question 21.]

[If no, then no further questions.]

12. Does the member have a diagnosis of hepatorenal syndrome? Y N

[If no, skip to question 15.]

13. Is octreotide prescribed by a hepatologist or nephrologist? Y N

[If no, then no further questions.]

14. Will octreotide be used in combination with midodrine and albumin? Y N

[If no, then no further questions.]

[If yes, skip to question 21.]

15. Does the member have a diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)? Y N

[If no, skip to question 18.]

16. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

[If no, then no further questions.]

17. Did the member have persistent disease after surgical resection, or is the member not a candidate for surgery? Y N

[If no, then no further questions.]

[If yes, skip to question 21.]

18. Is the request for a pediatric member with chemotherapy-induced diarrhea? Y N

[If no, skip to question 20.]

19. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

[No further questions.]

20. Does the member have any of the following diagnoses? A) Dumping Syndrome, B) Short bowel syndrome with diarrhea, C) hyperthyroidism due to thyrotropinoma, D) Enterocutaneous fistula, or E) Portal hypertension and/or upper GI bleed related from esophageal varices Y N

If yes, indicate which diagnosis: _____

[If no, then no further questions.]

21. Is the member at least 18 years of age? Y N

    [No further questions.]

22. Has the member had a positive clinical response and/or symptom improvement since starting octreotide? Y N

    [If no, then no further questions.]

23. Is the member's A1c and/or fasting glucose level controlled? Y N

    If no, submit documentation describing treatment plan to improve blood glucose: _____

    [If no, then no further questions.]

24. Does the member have a diagnosis of acromegaly? Y N

    [If no, skip to question 26.]

25. Has the member's IGF-1 level decreased or normalized since starting octreotide? Y N

    Please submit labs or document result and test date:
    _____

    [No further questions.]

26. Does the member have a diagnosis of carcinoid tumor or VIPomas? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**