Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Somatostatin Analogs (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 Somatostatin Analogs (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Signifor LAR (pasireotide for injectable suspension) Sigifor (pasireotide)

Sandostatin LA Depot (octreotide acetate for injectable suspension) Somatuline Depot (lanreotide)

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 30.] Y N

2. Is the request for Sandostatin LAR? Y N

   [If no, skip to question 5.] Y N

3. Have baseline A1c or fasting glucose, TSH, and EKG been checked? Y N

   Please submit labs or document results and dates: Y N

_____

[If no, then no further questions.] Y N

4. Has the member had a positive response to octreotide immediate release injection for at least 2 weeks? Y N

   [If yes, skip to question 17.] [If no, then no further questions.] Y N

5. Is the request for Signifor (but NOT Signifor LAR)? Y N

   [If no, skip to question 11.] Y N

6. Have baseline A1c, fasting plasma glucose, EKG, potassium, magnesium, TSH, and LFTs been checked? Y N

   Please submit labs or document results and dates: Y N

_____

[If no, then no further questions.] Y N

7. Has a gallbladder ultrasound been completed? Y N

   [If no, no further questions.] Y N

8. Does the member have a diagnosis of Cushing's Syndrome? Y N

   [If no, then no further questions.] Y N

9. Does the member have persistent disease after pituitary surgery, or is surgery not an option for this member? Y N

   [If no, then no further questions.] Y N

10. Has the member had a trial and failure of cabergoline or 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: Y N

_____

[If no, then no further questions.] [If yes, skip to question 29.] Y N

11. Has the member had a trial and failure of Sandostatin LAR, or an intolerance to octreotide or Sandostatin LAR? Y N

    [If no, then no further questions.] Y N

12. Is the request for Signifor LAR? Y N

[If no, skip to question 15.] Y N

13. Have baseline A1c, fasting plasma glucose, EKG, potassium, magnesium, TSH, and LFTs been checked? Y N

    Please submit labs or document results and dates: Y N

    _____

    [If no, then no further questions.] Y N

14. Has a gallbladder ultrasound been completed? Y N

    [If yes, skip to question 22.] Y N

15. Is the request for Somatuline Depot? Y N

    [If no, then no further questions.] Y N

16. Has a baseline A1c or fasting glucose been checked? Y N

    Please submit labs or document results and dates: _____ Y N

    [If no, then no further questions.] Y N

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

    [If yes, skip to question 21.] Y N

18. Will the requested medication be used to reduce the frequency of short acting somatostatin analog rescue therapy? Y N

    [If no, no further questions.] Y N

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

    [If no, skip to question 22.] Y N

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

    [If no, then no further questions.] Y N

21. Is the requested drug prescribed by or in consultation with an oncologist or endocrinologist? Y N

    [If no, then no further questions.] [If yes, skip to question 29.] Y N

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

[If no, then no further questions.] Y N

23. Is the requested drug prescribed by or in consultation with an endocrinologist? Y N

[If no, then no further questions.] Y N

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

[If yes, skip to question 26.] Y N

25. Is surgical resection not an option for this member due to ANY 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.] Y N

26. 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, skip to question 29.] Y N

27. 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

[If yes, skip to question 29.] Y N

28. 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: Y N

_____

[If no, then no further questions.] Y N

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

[No further questions.] Y N

30. Has the member had a clinical response and/or symptom improvement since starting medication? Y N

[If no, then no further questions.] Y N

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

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

    [If no, then no further questions.] Y N

32. Is this a renewal for Signifor for treatment of Cushing's syndrome? Y N

    [If no, skip to question 36.] Y N

33. Has the member's cortisol level decreased or normalized since starting Signifor? Y N

    Please submit labs or document result and test date: _____ Y N

    [If no, then no further questions.] Y N

34. Have LFT's been checked since starting Signifor? Y N

    [If no, then no further questions.] Y N

35. Were LFT's 5 times the upper limit of normal (UNL) or higher? Y N

    Please submit labs or document result and test date: _____ Y N

    [No further questions.] Y N

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

    [If no, skip to question 38.] Y N

37. Has the member's IGF-1 level decreased or normalized since starting the requested medication? Y N

    Please submit labs or document result and test date: _____ Y N

    [No further questions.] Y N

38. 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**