SANDOSTATIN® (octreotide acetate injection)
MYCAPSSA® (octreotide delayed-release capsule)
SANDOSTATIN® LAR DEPOT (octreotide acetate for injectable suspension)
Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Octreotide acetate injection** ☐ **Sandostatin injection** ☐ **Sandostatin LAR Depot** ☐ **Mycapssa**

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):

☐ **Acromegaly**
- ☐ Yes ☐ No Is this request for Mycapssa?
  - → ☐ Yes ☐ No Has the patient previously responded to and tolerated treatment with octreotide or lanreotide?
- ☐ 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

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

☐ **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?

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aetna®

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For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ **Cancer related diarrhea**
☐ 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)?

☐ **Carcinoid syndrome**

☐ **Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy**
☐ Yes ☐ No Is this medication request for Bynfezia Pen or Sandostatin LAR Depot?

☐ **Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)**

☐ **Enterocutaneous fistula (management of volume depletion from enterocutaneous fistula)**

☐ **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)**

☐ **Pheochromocytoma**

☐ **Paraganglioma**

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

☐ **Pituitary adenoma**

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

☐ **Thymoma or thymic carcinoma**

☐ **Vasoactive intestinal peptide tumors (VIPomas) (management of symptoms related to hormone hypersecretion)**

☐ **Zollinger-Ellison syndrome**

☐ **Other**

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

☐ **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.