OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Sandostatin®, Sandostatin® LAR Depot & octreotide acetate Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Acromegaly
- ❑ Carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing
- ❑ Chemotherapy- and/or radiation-induced diarrhea
- ❑ HIV/AIDS-related diarrhea
- ❑ Vasoactive intestinal peptide tumor requiring symptomatic treatment of diarrhea
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

For brand Sandostatin requests:

Has the patient had history of trial and failure, contraindication, or intolerance to generic octreotide acetate? ❑ **Yes** ❑ **No**

For Sandostatin LAR Depot requests:

Has the patient had a trial of short-acting octreotide and responded to and tolerated therapy? ❑ **Yes** ❑ **No**

For acromegaly, also answer the following:

Does the patient have acromegaly as confirmed by serum GH level greater than 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) or elevated serum IGF-1 levels (above age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis? ❑ **Yes** ❑ **No**

Has the patient had an **inadequate response or history of failure** to surgical resection and/or pituitary irradiation (radiotherapy) or is not a candidate for surgical resection or pituitary irradiation? ❑ **Yes** ❑ **No**

Has the patient had an **inadequate response or history of failure** to a dopamine agonist (e.g., bromocriptine, cabergoline)? ❑ **Yes** ❑ **No**

Does the patient have history of **intolerance** to dopamine agonist therapy at maximally tolerated doses? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)? ❑ **Yes** ❑ **No**

Sandostatin®, Sandostatin LAR Depot® & octreotide acetate
Prior Authorization Request Form (Page 2 of 2)

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For carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing, also answer the following:

Does the patient have metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes? ❑ **Yes** ❑ **No**

Is this request for continuation of therapy and the patient has used the requested medication within the past 120 days? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive response while on therapy (improvement in the number of diarrhea or flushing episodes)? ❑ **Yes** ❑ **No**

For chemotherapy- and/or radiation-induced diarrhea, also answer the following:

Does the patient have **uncomplicated** diarrhea due to concurrent cancer chemotherapy and/or radiation? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to standard therapy (e.g., loperamide)? ❑ **Yes** ❑ **No**

Does the patient have **complicated** diarrhea due to concurrent cancer chemotherapy and/or radiation? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive response while on therapy? ❑ **Yes** ❑ **No**

For HIV/AIDS-related diarrhea, also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to standard therapy (e.g., loperamide, diphenoxylate with atropine)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive response while on therapy? ❑ **Yes** ❑ **No**

For vasoactive intestinal peptide tumor requiring symptomatic treatment of diarrhea, also answer the following:

Does the patient have vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea? ❑ **Yes** ❑ **No**

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive response while on therapy (improvement in the number of diarrhea episodes)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.