



MEDICARE FORM
Somatuline Depot (lanreotide),
Lanreotide injection (Cipla)
(lanreotide acetate injection)
Medication Precertification Request

Virginia (HMO D-SNP)
 FAX: 1-833-280-5224
 PHONE: 1-855-463-0933

For other lines of business:
 Please use other form.

Note: Lanreotide (Cipla) is non-preferred. Sandostatin LAR and Somatuline Depot are preferred.

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

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:			
Address:		City:	State:	ZIP:	
Home Phone:		Work Phone:		Cell Phone:	
DOB:	Allergies:			E-mail:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms			
B. INSURANCE INFORMATION					
Aetna Member ID #:		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #:		If yes, provide ID#: _____ Carrier Name: _____			
Insured:		Insured: _____			
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				If yes, provide ID #: _____	
C. PRESCRIBER INFORMATION					
First Name:		Last Name: (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					
D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION					
Place of Administration:			Dispensing Provider/Pharmacy: Patient Selected choice		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____		
Center Name: _____			Name: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Address: _____		
Agency Name: _____			Phone: _____ Fax: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			TIN: _____ PIN: _____		
Address: _____					
E. PRODUCT INFORMATION					
Request is for: <input type="checkbox"/> Somatuline Depot (lanreotide) <input type="checkbox"/> Lanreotide Injection (Cipla)					
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 <u>entirety</u> for all precertification requests.					
For Initiation Requests (clinical documentation required for all requests):					
Note: Lanreotide (Cipla) is non-preferred. Sandostatin LAR and Somatuline Depot (lanreotide) are preferred.					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Lanreotide (Cipla) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)					
<input type="checkbox"/> Sandostatin LAR (octreotide acetate) <input type="checkbox"/> Somatuline Depot (lanreotide)					
Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)					
<input type="checkbox"/> Sandostatin LAR (octreotide acetate) <input type="checkbox"/> Somatuline Depot (lanreotide)					

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Acromegaly

Yes No Has the patient had an inadequate or partial response to surgery or radiotherapy?
 → Yes No Is the 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 compare 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
- IGF-1 level falls within the laboratory's normal range

Carcinoid syndrome

Please indicate which clinical setting the requested medication will be used:

- Single agent
- In combination with telotristat for persistent diarrhea due to poorly controlled carcinoid syndrome
- In combination with other systemic therapy options for persistent symptoms such as flushing or diarrhea, or for progressive disease
- Other

Primary gastrinoma, unresected

Well-differentiated grade 3 Neuroendocrine tumors (NETs) with favorable biology, unresectable locally advanced or metastatic NETs with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)

- Neuroendocrine tumors of the gastrointestinal tract (carcinoid tumors), locoregional advanced or metastatic
- Neuroendocrine tumors of the thymus (carcinoid tumors), unresectable or metastatic
- Neuroendocrine tumors of the lung (carcinoid tumors), unresectable or metastatic
- Neuroendocrine tumors of the pancreas (islet cell tumors, including gastrinomas, glucagonomas, insulinomas and VIPomas)
- Gastroenteropancreatic neuroendocrine tumor, unresectable, well or moderately-differentiated, locally advanced or metastatic
- Pheochromocytoma, locally unresectable or metastatic
- Paraganglioma, locally unresectable or metastatic
- Zollinger-Ellison syndrome
- Other

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

Acromegaly

Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
 Increase Decreased or normalized No change

Carcinoid syndrome

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.