



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Somatostatin Analogs & Somavert Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#		DEA#	
Office Address:	City:	State:		Zip Code:	
Office Contact:	Office Phone		Office Fax:		
Dispensing Pharmacy Information					
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information					
Preferred Agents:	<input type="checkbox"/> Octreotide	<input type="checkbox"/> Sandostatin Long Acting Release (LAR)			
Non-Preferred Agents:	<input type="checkbox"/> Signifor	<input type="checkbox"/> Signifor LAR	<input type="checkbox"/> Somatuline Depot	<input type="checkbox"/> Somavert	
Are there any contraindications to formulary medications? If yes, please specify:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No		Diagnosis:		ICD-10 Code:	
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has member tried and failed for this diagnosis?					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information					
<input type="checkbox"/> Sandostatin LAR			<input type="checkbox"/> Somatuline Depot		
Baseline Testing:	<input type="checkbox"/> A1C or fasting glucose	<input type="checkbox"/> Thyroid-stimulating hormone	<input type="checkbox"/> Electrocardiography		
<input type="checkbox"/> Signifor		<input type="checkbox"/> Signifor (LAR)			
Baseline Testing:	<input type="checkbox"/> Potassium	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Thyroid-Stimulating Hormone	<input type="checkbox"/> A1C or fasting plasma glucose	
	<input type="checkbox"/> Liver Function Tests		<input type="checkbox"/> Gallbladder Ultrasound	<input type="checkbox"/> Electrocardiography	
<input type="checkbox"/> Somavert					
Baseline Testing:	<input type="checkbox"/> LFTs are < 3x upper limit of normal				
Additional Criteria Based on Indication					

<input type="checkbox"/> Acromegaly			
Member has ONE of the following:	<input type="checkbox"/> Persistent disease following radiotherapy AND/OR pituitary surgery	<input type="checkbox"/> Surgical resection is NOT an option as evidenced by ONE of the following:	<input type="checkbox"/> Majority of tumor cannot be resected
			<input type="checkbox"/> Member is a poor surgical candidate based on comorbidities
			<input type="checkbox"/> Member prefers medical treatment over surgery OR refuses surgery
Baseline IGF-1 meets ONE of the following:	<input type="checkbox"/> ≥ 2.5 times the upper limit of normal for age	<input type="checkbox"/> Remains elevated despite a 6-month trial of maximally tolerated dose of cabergoline (unless member cannot tolerate, or has contraindication to cabergoline)	

Carcinoid Tumor or Vasoactive Intestinal Polypeptide Secreting Tumor (VIPomas)

Cushing's Syndrome

Has member had persistent disease after pituitary surgery OR surgery is NOT an option?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did member have inadequate response, intolerable side effects OR contraindication to cabergoline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Hepato-Renal Syndrome

Will Octreotide be used in combination with midodrine and albumin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Gastro-entero-pancreatic neuroendocrine tumor

Has member had persistent disease after surgical resection OR is NOT a candidate for surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Renewal Requests ONLY

Response to therapy for ALL includes:	<input type="checkbox"/> A1C or fasting glucose	<input type="checkbox"/> TSH	<input type="checkbox"/> Electrocardiography	<input type="checkbox"/> Monitor for cholelithiasis AND D/C if complications of cholelithiasis suspected
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Acromegaly

Decreased or normalized IGF-1 levels	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Cushing's Syndrome

Decreased or normalized cortisol levels	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Signifor

Liver Function Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Somavert

Liver Function Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required. Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.