mercy care

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/chp-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: ☐ Male ☐ Female	Height:
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:	☐ **Octreotide**	☐ **Sandostatin Long Acting Release (LAR)**		
Non-Preferred Agents:	☐ Signifor	☐ Signifor LAR	☐ Somatuline Depot	☐ Somavert

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ 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	
☐ Standard – (24 hours)	☐ **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				
☐ **Sandostatin LAR**		☐ **Somatuline Depot**		
Baseline Testing:	☐ A1C or fasting glucose	☐ Thyroid-stimulating hormone	☐ Electrocardiography	
☐ **Signifor**	☐ **Signifor (LAR)**			
☐ Baseline Testing:	☐ Potassium	☐ Magnesium	☐ Thyroid-Stimulating Hormone	☐ A1C or fasting plasma glucose
	☐ Liver Function Tests		☐ Gallbladder Ultrasound	☐ Electrocardiography
☐ **Somavert**				
Baseline Testing:	☐ LFTs are < 3x upper limit of normal			
Additional Criteria Based on Indication				

☐ **Acromegaly**			
Member has ONE of the following:	☐ Persistent disease following radiotherapy AND/OR pituitary surgery	☐ Surgical resection is NOT an option as evidenced by ONE of the following:	☐ Majority of tumor cannot be resected ☐ Member is a poor surgical candidate based on comorbidities ☐ Member prefers medical treatment over surgery OR refuses surgery
Baseline IGF-1 meets ONE of the following:	☐ ≥2.5 times the upper limit of normal for age	☐ 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?	☐ Yes	☐ No	Did member have inadequate response, intolerable side effects OR contraindication to cabergoline?	☐ Yes	☐ No
☐ **Hepato-Renal Syndrome**					
Will Octreotide be used in combination with midodrine and albumin?				☐ Yes	☐ No
☐ **Gastro-entero-pancreatic neuroendocrine tumor**					
Has member had persistent disease after surgical resection OR is NOT a candidate for surgery?				☐ Yes	☐ No

☐ **Renewal Requests ONLY**				
Response to therapy for ALL includes:	☐ A1C or fasting glucose	☐ TSH	☐ Electrocardiography	☐ Monitor for cholelithiasis AND D/C if complications of cholelithiasis suspected
☐ **Acromegaly**				
Decreased or normalized IGF-1 levels	☐ Yes	☐ No		
☐ **Cushing's Syndrome**				
Decreased or normalized cortisol levels	☐ Yes	☐ No		
☐ **Signifor**				
Liver Function Tests	☐ Yes	☐ No		
☐ **Somavert**				
Liver Function Tests	☐ Yes	☐ No		

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 833-711-0776 to check the status of a request.