PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Lanreotide Extended Release

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is the request for Somatuline for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response to Somatuline?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of acromegaly? If YES, go to 4. If NO, go to 7.

☐ Yes ☐ No

Q4. Is baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender above the upper limit of normal based on laboratory reference range?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response to surgery or radiation therapy? If YES, go to 9. If NO, go to 6.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Lanreotide Extended Release

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Is there a clinical reason why the patient has not had surgery or radiation therapy? If YES, go to 9.

☐ Yes ☐ No

Q7. Does the patient have a documented diagnosis of unresectable, well or moderately differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors.? If YES, go to 9. If NO, go to 8.

☐ Yes ☐ No

Q8. Does the patient have a documented diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea?

☐ Yes ☐ No

Q9. Is octreotide being prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist?

☐ Yes ☐ No

Q10. Requested Duration

☐ 12 months ☐ Other

Q11. Additional Information

____________________________ ____________________

Prescriber Signature Date

v2025

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document