



**MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

Octreotide - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

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.**

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	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 applying the 72 hour 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 octreotide for reauthorization?

Yes

No

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

Yes

No

Q3. Does the patient have a documented diagnosis of acromegaly?

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?

Yes

No

Q6. Is there a clinical reason why the patient has not had surgery or radiation therapy?



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<b>Member Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have a documented diagnosis of metastatic carcinoid tumor?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient require symptomatic treatment of severe diarrhea or flushing episodes?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is octreotide being prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other
Q12. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2025