Endocrine and Metabolic: Somatostatic Agents

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   - If yes, is there documentation demonstrating disease stability or a positive clinical response (e.g., normalization of serum IGF-1, normalization of growth hormone, adenoma shrinkage, improvement of flushing, improvement of diarrhea, reduction in tumor volume, decrease in urine free cortisol)?
     ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Endocrinologist ☐ Oncologist ☐ Other. Specify:

3. Will this medication be used in combination with another somatostatic agent (e.g. lanreotide, octretide)?
   ☐ Yes ☐ No

4. Indicate patient's diagnosis and answer the associated questions:
   ☐ Acromegaly
   - Is provider able to attest that the patient is not a candidate for surgery to treat Acromegaly?
     ☐ Yes ☐ No
   - If request is for Mycapssa, provide the following:
     - Has documentation been included demonstrating response and tolerance to treatment with octreotide or lanreotide? ☐ Yes ☐ No
     - Explain why the patient is unable to use injectable octreotide or lanreotide:

   ☐ Carcinoid syndrome
   - Is patient experiencing symptoms related to carcinoid syndrome (e.g., diarrhea, flushing)?
     ☐ Yes ☐ No

   ☐ Cushing's Syndrome
   - Is provider able to attest that the patient has failed or is not a candidate for surgery to treat Cushing's Syndrome? ☐ Yes ☐ No

   ☐ Severe or persistent diarrhea due to chemotherapy
   - Does the patient have a history of failure, contraindication, or intolerance to loperamide?
     ☐ Yes ☐ No

☐ Vasoactive intestinal peptide-secreting tumor (VIPoma)
- Is the request for the management of diarrhea due to VIPoma? ☐ Yes ☐ No

☐ Gastroenteropancreatic neuroendocrine tumor
- Has patient been diagnosed with gastroenteropancreatic neuroendocrine tumor that is unresectable, well- or moderately-differentiated, locally advanced or metastatic? ☐ Yes ☐ No

☐ Other. Specify:

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)