Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Sandostatin LAR Depot
(octreotide LAR Depot)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)* ICD10:

☐ Octreotide acetate ER powder for injection 10mg
☐ Octreotide acetate ER powder for injection 20mg
☐ Sandostatin LAR Depot 10mg
☐ Octreotide acetate ER powder for injection 30mg
☐ Sandostatin LAR Depot 20mg
☐ Sandostatin LAR Depot 30 mg

Strength and Dosing:

Is this a new start or continuation of therapy**? ☐ new start of therapy ☐ Continuation of therapy- start date:

If your patient has already begun treatment with drug samples, please choose "new start of therapy". OR if patient has had a break in therapy and is restarting, please choose "new start of therapy".

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

***Cigna's nationally preferred specialty pharmacy*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Please indicate the condition octreotide ER, or Sandostatin LAR is being used to treat and answer additional questions as necessary.

Diagnosis

☐ Acromegaly
☐ Diarrhea Associated with Chemotherapy
☐ Enterocutaneous Fistulas
☐ Merkel Cell Carcinoma
☐ Meningioma
☐ Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas)
☐ Pancreatic Fistulas
☐ Pheochromocytoma and Paraganglioma
☐ Thymoma and Thymic Carcinoma
☐ Small bowel bleeds/angiodysplasia related bleeding
☐ Other

Clinical Information

(if acromegaly) Has the patient had an inadequate response to surgery and/or radiotherapy? ☐ Yes ☐ No

(if no) Is the patient a candidate for surgery and/or radiotherapy? ☐ Yes ☐ No

(if yes) Is the patient experiencing negative effects due to tumor size (for example, optic nerve compression)? ☐ Yes ☐ No

(if acromegaly) Prior to starting any somatostatin analog (for example, Mycapssa [octreotide delayed-release capsules], an octreotide acetate injection product [for example, Bynfezia Pen, Sandostatin {generic}, Sandostatin LAR Depot], Signifor LAR [pasireotide injection], Somatuline Depot [lanreotide injection], dopamine agonist [for example, cabergoline, bromocriptine], or Somavert [pegvisomant injection]), does/did the patient have an insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory (note that references ranges for IGF-1 vary among laboratories)? ☐ Yes ☐ No

(if acromegaly) Is the requested medication being prescribed by (or in consultation with) an endocrinologist? ☐ Yes ☐ No

(if diarrhea associated with chemotherapy) Does the patient have Grade 3 or Grade 4 diarrhea? Note: Examples of Grade 3 or Grade 4 diarrhea include more than 6 bowel movements above baseline per day, colitis symptoms, interference with activities of daily living, hemodynamic instability, hospitalization, serious complications (for example, ischemic bowel, perforation, toxic mega-colon), or other colitis-related life-threatening conditions. ☐ Yes ☐ No

(if diarrhea associated with chemotherapy) Has the patient tried at least one antimotility medication? Note: Examples of antimotility medications include loperamide and diphenoxylate. ☐ Yes ☐ No

(if diarrhea associated with chemotherapy) Is the requested medication being prescribed by (or in consultation with) an oncologist or gastroenterologist? ☐ Yes ☐ No

(if Meningioma) Is the requested medication being prescribed by (or in consultation with) an oncologist, radiologist, or neurosurgeon? ☐ Yes ☐ No

(if NETs) Is the requested medication being prescribed by (or in consultation with) an oncologist, endocrinologist, or gastroenterologist? ☐ Yes ☐ No

(if Pancreatic Fistulas) Is the patient being treated for operative trauma, pancreatic resection, acute or chronic pancreatitis, or pancreatic infection? ☐ Yes ☐ No

(if Pheochromocytoma and Paraganglioma) Is the requested medication being prescribed by (or in consultation with) an endocrinologist, oncologist, or neurologist? ☐ Yes ☐ No

(if Thymoma and Thymic Carcinoma) Is the requested medication being prescribed by (or in consultation with) an oncologist? ☐ Yes ☐ No

(if Merkel Cell Carcinoma) Does the patient have regional or distant metastatic disease? ☐ Yes ☐ No

(if Merkel Cell Carcinoma) Does the patient have contraindications to a programmed death-ligand 1 (PD-L1) or programmed death-1 (PD-1) inhibitor? Note: PD-L1/ P-1 inhibitors includes Bavencio (avelumab intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), and Zynyz (retifanlimab-dlwr intravenous infusion). ☐ Yes ☐ No

Has the patient's disease progressed on a programmed death-ligand 1 (PD-L1) or programmed death-1 (PD-1) inhibitor? Note: PD-L1/ P-1 inhibitors includes Bavencio (avelumab intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), and Zynyz (retifanlimab-dlwr intravenous infusion). ☐ Yes ☐ No

(if Merkel Cell Carcinoma) Is the requested medication being prescribed by (or in consultation with) an oncologist? ☐ Yes ☐ No

(if Small bowel bleeds/angiodysplasia related bleeding) Does the patient have chronic, recurrent gastrointestinal bleeds lasting greater than or equal to 3 months? ☐ Yes ☐ No

(if Small bowel bleeds/angiodysplasia-related bleeding) Is this medication being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

If requesting brand Sandostatin LAR Depot:

(if acromegaly) Has the patient tried ONE of octreotide ER injectable suspension, Somatuline Depot or lanreotide subcutaneous injection? NOTE: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67. ☐ Yes ☐ No

(if NETs) Has the patient tried ONE of octreotide ER injectable suspension, Somatuline Depot or lanreotide subcutaneous injection? NOTE: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67. ☐ Yes ☐ No

(if no) Has the patient already been started on therapy with Sandostatin LAR? ☐ Yes ☐ No

(if Pheochromocytoma and Paraganglioma) Has the patient tried ONE of octreotide ER injectable suspension, Somatuline Depot or lanreotide subcutaneous injection? NOTE: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67. ☐ Yes ☐ No

(if no) Has the patient already been started on therapy with Sandostatin LAR? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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