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

Sandostatin, Sandostatin LAR Depot

(octreotide LAR Depot, octreotide immediate release)

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 1000mcg/5mL vial
☐ Octreotide 500mcg/mL vial
☐ Octreotide 100mcg/mL vial
☐ Octreotide 50mcg/mL vial
☐ Sandostatin 0.5mg/mL ampule
☐ Sandostatin LAR Depot 30mg
☐ Octreotide 500mcg/mL syringe
☐ Octreotide 0.05mg/mL vial
☐ Octreotide 200mcg/mL vial
☐ Sandostatin 0.05mg/mL ampule
☐ Sandostatin LAR Depot 10mg
☐ Octreotide 5000mcg/5mL vial
☐ Octreotide 100mcg/mL syringe
☐ Octreotide 50mcg/mL syringe
☐ Sandostatin 0.1mg/mL ampule
☐ Sandostatin LAR Depot 20mg

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".

(if continued therapy) Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

(if no) Please provide support for continued use.

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, Sandostatin, or Sandostatin LAR is being used to treat and answer additional questions as necessary.

☐	Acromegaly		
	Additional Questions:	Did the patient have an inadequate response to surgery and/or radiotherapy?	☐ Yes ☐ No
		(if no) Are surgery and/or radiotherapy NOT an option for this patient?	☐ Yes ☐ No
		(if no) Is the patient experiencing negative effects due to tumor size (for example, optic nerve compression)?	☐ Yes ☐ No
		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 your 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
		Is the medication prescribed by, or in consultation with, an endocrinologist?	☐ Yes ☐ No
		(if request is for Sandostatin LAR) Has the patient already been started on Sandostatin LAR?	☐ Yes ☐ No
		(if no and request is for Sandostatin LAR) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative. _____	
		(if request is for Sandostatin LAR and not already started on Sandostatin LAR) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?	☐ The patient tried the alternative, but it didn't work well enough. ☐ The patient is able to try the alternative, but has not done so yet. ☐ The patient tried the alternative, but they did not tolerate it. ☐ The patient cannot try the alternative because of a contraindication to this drug. ☐ Other

☐	adrenal gland tumor		
	Additional Questions:	Did your patient undergo SRS (somatostatin receptor scintigraphy)?	☐ Yes ☐ No
		Does your patient have non-adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome?	☐ Yes ☐ No
		(if yes) Were the results positive or negative?	☐ positive ☐ negative ☐ unknown
		What is the size of the tumor?	☐ smaller than 4 centimeters (cm) ☐ 4 centimeters (cm) or larger ☐ unknown
☐	acute gastroesophageal variceal hemorrhage		
☐	carcinoid tumor (for symptom control)		
	Additional Questions:	(if requesting Sandostatin LAR) Is the patient currently receiving the requested medication?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Does the patient have either Meningioma or Thymoma/Thymic Carcinoma?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Is the patient undergoing treatment with Lutathera?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.	
		(if requesting Sandostatin LAR and not undergoing treatment with Lutathera) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?	☐ The patient tried the alternative. ☐ The patient is able to try the alternative, but has not done so yet. ☐ The patient tried the alternative, but they didn't tolerate it. ☐ The patient cannot try the alternative because of a contraindication to this drug. ☐ Other
☐	Diarrhea associated with chemotherapy/radiation		

	Additional Questions:	What grade is the patient's diarrhea?	☐ Grade 1 ☐ Grade 2 ☐ Grade 3 ☐ Grade 4 ☐ Unknown
		(if Grade 1 or 2) Has your patient failed a trial of conservative medical management such as anti-motility agents?	☐ Yes ☐ No
☐	secretory diarrhea in AIDS		
	Additional Questions:	Has your patient had an inadequate response to antimicrobial or antimotility agents?	☐ Yes ☐ No
☐	entercutaneous fistula		
☐	meningioma		
	Additional Questions:	Is meningioma surgically unresectable? Does your patient have recurrent or progressive disease? Is further radiation possible?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐N o
☐	Neuroendocrine tumor of the GI tract, lung, or thymus		
	Additional Questions:	Does your patient have unresectable or metastatic disease?	☐ Yes ☐ No
		(if requesting Sandostatin LAR) Is the patient currently receiving the requested medication?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Does the patient have either Meningioma or Thymoma/Thymic Carcinoma?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Is the patient undergoing treatment with Lutathera?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.	
		(if requesting Sandostatin LAR and not undergoing treatment with Lutathera) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?	☐The patient tried the alternative. ☐ The patient is able to try the alternative, but has not done so yet. ☐ The patient tried the alternative, but they didn't tolerate it. ☐ The patient cannot try the alternative because of a contraindication to this drug ☐ Other
☐	Pancreatic neuroendocrine tumors (includes insulinoma, glucaconoma, vasoactive intestinal polypeptidoma, or VIPoma)		
	Additional Questions:	Does your patient have unresectable, locally advanced or metastatic disease?	☐ Yes ☐ No
		(if no) Is the medication being used for symptom control of a functioning PNET, such as insulinoma, glucagonoma, vasoactive	☐ Yes ☐ No

		intestinal polypeptidoma or VIPoma?	
		(if requesting Sandostatin LAR) s the patient currently receiving the requested medication?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Does the patient have either Meningioma or Thymoma/Thymic Carcinoma?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Is the patient undergoing treatment with Lutathera?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.	
		(if requesting Sandostatin LAR and not undergoing treatment with Lutathera) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?	☐The patient tried the alternative. ☐ The patient is able to try the alternative, but has not done so yet. ☐ The patient tried the alternative, but they didn't tolerate it. ☐ The patient cannot try the alternative because of a contraindication to this drug. ☐ Other
	pheochromocytoma/paraganglioma		
☐	Additional Questions:	Does your patient have locally unresectable disease?	☐ Yes ☐ No
		(if requesting Sandostatin LAR) Is the patient currently receiving the requested medication?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Does the patient have either Meningioma or Thymoma/Thymic Carcinoma?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) Is the patient undergoing treatment with Lutathera?	☐ Yes ☐ No
		(if no and requesting Sandostatin LAR) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.	
		(if requesting Sandostatin LAR and not undergoing treatment with Lutathera) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?	☐The patient tried the alternative, ☐ The patient is able to try the alternative, but has not done so yet. ☐ The patient tried the alternative, but they didn't tolerate it. ☐ The patient cannot try the alternative because of a contraindication to this drug. ☐ Other
	pituitary adenoma		
☐	Additional Questions:	Is adenoma secreting thyroid stimulating hormone (TSH)? Has your patient had an incomplete surgical resection?	☐ Yes ☐ No ☐ Yes ☐ No

☐	pancreatic resection (including fistula)		
	Additional Questions:	Is this being used for preoperative management?	☐ Yes ☐ No
☐	thymoma or thymic carcinoma		
	Additional Questions:	Is this being used as second-line therapy?	☐ Yes ☐ No
☐	Other		

Duration of therapy:

Alternatives tried: (*please include length of trial and/or if samples were given)*

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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