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".

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.

Diagnosis

☐ Acromegaly
☐ Enterocutaneous Fistulas
☐ 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
☐ None of the above

(if none of the above) Please provide the patient's diagnosis or reason for treatment.

Clinical Information

(if acromegaly) 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

(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 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

(if acromegaly) Is the requested medication being prescribed by (or in consultation with) an endocrinologist? ☐ 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 requesting Sandostatin LAR Depot, preferred product criteria must be met:

(if acromegaly) Has it been documented that the patient has tried Somatuline Depot? ☐ Yes ☐ No

(if NETs) Has it been documented that the patient has tried Somatuline Depot subcutaneous injection? ☐ Yes ☐ No

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

(if Pheochromocytoma and Paraganglioma) Has it been documented that the patient has tried Somatuline Depot? ☐ Yes ☐ No

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

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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005