Somatuline Depot
(lanreotide acetate)

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

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:
Somatuline Depot: ☐ Strength & Dosing: ICD10:

Is this a new start or continuation of therapy**? ☐ new start of therapy ☐ continued therapy- start date:
If your patient has already begun treatment with drug samples, please choose "new start of therapy".

(if continued therapy) Does your patient have evidence of beneficial clinical response to therapy with the requested medication?
Yes ☐ No ☐

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

Diagnosis related to use:
☐ acromegaly
☐ adrenal gland tumors
☐ carcinoid tumors
☐ gastroenteropancreatic neuroendocrine tumors (GEP- NETs) (including carcinoid syndrome, Zollinger-Ellison syndrome)
☐ neuroendocrine tumor (NET) of the GI tract, lung or thymus
☐ neuroendocrine tumor (NET) of the pancreas (includes insulinoma, glucagonoma, vasoactive intestinal polypiptidoma or VIPoma)
☐ pheochromocytoma/paraganglioma
☐ pituitary adenoma
☐ Other *(please specify)*:

Clinical Information:
(if adrenal gland tumor) Did your patient undergo SRS (somatostatin receptor scintigraphy)? ☐ Yes ☐ No
(if yes) Were the results positive or negative? ☐ positive ☐ negative

(if adrenal gland tumor) What is the size of the tumor?

- ☐ 3 centimeters (cm) or less
- ☐ 4 or more centimeters (cm)
- ☐ unknown

(if adrenal gland tumor) Does your patient have non-adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome? ☐ Yes ☐ No

(if GEP-NETs) Does your patient have unresectable, locally advanced, or metastatic disease? ☐ Yes ☐ No

(if NET of GI tract, lung, or thymus) Is the neuroendocrine tumor unresectable or metastatic? ☐ Yes ☐ No

(if pituitary adenoma) Is the adenoma producing thyroid-stimulating hormone (TSH)? ☐ Yes ☐ No

(if pituitary adenoma) Has your patient had an incomplete surgical resection? ☐ Yes ☐ No

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

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

(if pheochromocytoma/paraganglioma) Does your patient have locally unresectable disease? ☐ 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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