

Sandostatin Lar Depot Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.

Please complete all sections of this form. Incomplete responses may delay this request.

| | | | |
|--|---|---|---|
| Office Contact: | | Provider Specialty: | |
| Provider First Name: | | Provider Last Name: | |
| Provider Phone: | | Provider Fax: | |
| Patient Name: | Patient UPMC Health Plan ID Number: | Patient Age: | Patient DOB: |
| Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic | Strength: | Frequency: | Expected length of therapy: |
| <i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i> | | | |
| <input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication | If ongoing, provide date started: | If medication is ongoing, Did member Show improvement while on therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Place of administration? <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility | Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient | | |
| Please provide facility/provider name and address: | | | |
| Please indicate the diagnosis and answer the corresponding questions: | | | |
| <input type="checkbox"/> Acromegaly | Is the medication being prescribed by or in consultation with an endocrinologist? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Please provide the member's IGF-1 level: _____ | | |
| | Laboratory reference range: _____ | | |
| | Date of test _____ | | |
| | Please provide the member's Growth Hormone (GH) level during oral glucose tolerance test _____ | | |
| Date of Test: _____ | | | |
| Did the member have an inadequate response to surgery or radiation? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If no, Please provide documentation that these therapies are not appropriate. | | | |
| <input type="checkbox"/> Chart documentation enclosed <input type="checkbox"/> Chart documentation not available | | | |
| <input type="checkbox"/> Metastatic carcinoid tumor | Does the member have severe diarrhea and flushing episodes? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is the medication being prescribed by or in consultation with a hematologist, oncologist, endocrinologist, or palliative care specialist? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Vasoactive intestinal peptide secreting tumors | Does the member have profuse watery diarrhea? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is the medication being prescribed by or in consultation with a hematologist, oncologist, endocrinologist, or palliative care specialist? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other Diagnosis, please list: | Please provide clinical literature/studies to support request for off-label use. <input type="checkbox"/> Clinical literature/studies enclosed <input type="checkbox"/> Clinical literature/studies not available | | |
| Please provide any additional information which should be considered in the space below: | | | |
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