| Prescriber Criteria Form<br>Sandostatin 2026 PA Fax 4361-A v1 010126.docx<br>Sandostatin (octreotide acetate injection)<br>Coverage Determination |
|---|
| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sandostatin (octreotide acetate injection). |

| Drug Name:<br>Sandostatin (octreotide acetate injection) |
|---|

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Does the patient have a diagnosis of acromegaly?<br>[If no, then skip to question 6.] | Yes | No |
| 2 | Is the patient currently receiving therapy with the requested drug?<br>[If no, then skip to question 4.] | Yes | No |
| 3 | Has the patient's insulin-like growth factor-1 (IGF-1) level decreased or normalized since initiation of therapy?<br>[No further questions.] | Yes | No |
| 4 | Does the patient have a high pre-treatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range?<br>[If no, then no further questions.] | Yes | No |
| 5 | Does the patient meet any of the following criteria: A) the patient had an inadequate or partial response to surgery or radiotherapy, B) there is a clinical reason for why the patient has not had surgery or radiotherapy?<br>[No further questions.] | Yes | No |
| 6 | Is the requested drug prescribed for any of the following: A) treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumor, B) treatment of profuse watery diarrhea associated with a vasoactive intestinal peptide tumor (VIPoma)-secreting | Yes | No |

| | | | |
|---|---|---|---|
| | tumor?<br>[If yes, then no further questions.] | | |
| 7 | Is the requested drug being prescribed for tumor control of a thymoma or thymic carcinoma? | Yes | No |

| | |
|---|---|
| Comments: | _____ |

| |
|---|
| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
| **Prescriber (or Authorized) Signature:** _____ **Date:**_____ |