ATRIO HEALTH PLANS

Somatostatic Agents Step Therapy

Somatuline Depot (lanreotide acetate) J1930 is non-preferred. The preferred product is Sandostatin (octreotide) J2353

Prior Authorization Step Therapy Medicare Part B Request Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	Date Requested _____
	Requestor _____ Clinic name: _____ Phone / Fax

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Somatostatic Agents PA

Drug Name(s):

SOMATULINE DEPOT INJECTION	**LANREOTIDE ACETATE**
SANDOSTATIN	**OCTREOTIDE**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Sandostatin** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approvals will be for 12 months

FDA Indications:
Somatuline Depot

- Acromegaly
- Carcinoid syndrome
- Neuroendocrine tumor, gastroenteropancreatic

Sandostatin

- Acromegaly, Inadequate response to or ineligible for surgery, radiation, or bromocriptine mesylate
- Acromegaly, Long-term maintenance with response to and tolerance of octreotide or lanreotide
- Carcinoid syndrome, Metastatic; symptomatic treatment
- Vasoactive intestinal peptide-secreting tumor, Associated diarrhea

Off-Label Uses:
Somatuline Depot

- Carcinoid tumor of stomach
- Portal hypertension

Sandostatin

- AIDS – Diarrhea
- Bleeding esophageal varices
- Chylothorax
- Cryptosporidiosis.
- Diabetes mellitus.
- Drug-induced hypoglycemia, Sulfonylurea.
- Dumping syndrome.

- Hypothalamic obesity.
- Lymphorrhea.
- Necrotizing pancreatitis, acute; Adjunct.
- Neuroendocrine tumor
- Non-infective diarrhea.
- Pituitary adenoma.
- Polycystic ovary syndrome.
- Polyostotic fibrous dysplasia of bone; Adjunct.
- Zollinger-Ellison syndrome; Adjunct

Age Restrictions:

- Safety and effectiveness of ocrelizumab have not been established in pediatric patients
- Chylothorax: Off-label Dosage
    - Dosage (less 18 years): Initial mean dose of 4 mcg/kg/hr as a continuous infusion, with a maximum mean dose of 6 mc/kg/hr (7 days to 36 months) 4 to 10 mcg/kg/hr as a continuous infusion

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/3A4CAB/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/C7E48F/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Lanreotide&UserSearchTerm=Lanreotide&SearchFilter=filterNone&navitem=searchGlobal#

https://careweb.careguidelines.com/ed24/ac/ac04_096.htm

https://www.micromedexsolutions.com/micromedex2/librarian/CS/082AA0/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/E2E20C/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Octreotide&UserSearchTerm=Octreotide&SearchFilter=filterNone&navitem=searchGlobal#

https://careweb.careguidelines.com/ed24/ac/ac04_082.htm