



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
**Fax: 1-866-374-1579**

## Sandostatin

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. What drug is being prescribed?  
 Sandostatin Injection (octreotide)    Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Sandostatin LAR Depot                    Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Other \_\_\_\_\_
2. What is the diagnosis?  
 Acromegaly                     Vasoactive intestinal peptide tumors (VIPomas)  
 Carcinoid tumor             Other \_\_\_\_\_
3. **What is the ICD-9 code?** \_\_\_\_\_
4. Is the patient currently receiving Sandostatin therapy?     Yes     No    *\*If No, skip to Dx Section*
5. What form of therapy is patient **currently** on?     Sandostatin Injection (octreotide)  
 Sandostatin LAR Depot
6. Was the treatment with octreotide injection tolerable?     Yes     No
7. If Sandostatin LAR Depot is prescribed dosage form, are the patient's motor skills or visual ability impaired such that patient cannot safely self-inject?     Yes     No    **(Fax supporting documentation)**

**Complete the Section below designated for the patient's diagnosis (Sections A-C)**

**SECTION A: Diagnosis Acromegaly**

8. Does the patient have clinical evidence of acromegaly (e.g., frontal bossing, coarse facial features, wide nasal bridge, thick lips)?     Yes     No
9. Document **pretreatment** IGF-1 level: \_\_\_\_\_
10. Does the patient have a documented high IGF-1 level for age and gender?     Yes     No
11. Has the patient had a trial and failure of cabergoline or maximum doses of bromocriptine?  
 Yes     No

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Patient Name: \_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_  
Patients ID : \_\_\_\_\_

12. Is the patient contraindicated to cabergoline or bromocriptine therapy?  Yes  No
13. Has the patient had an inadequate response to surgery and/or radiotherapy?  Yes  No
14. Is the patient a candidate for surgery or radiotherapy?  Yes  No
15. Is Sandostatin being used adjunctively during radiation treatment?  Yes  No
16. Will Sandostatin be withdrawn for approximately 4 weeks once a year to assess signs and symptoms following irradiation?  Yes  No

**Only answer below questions if patient is currently on Sandostatin for Acromegaly**

17. Document **current** IGF-1 level: \_\_\_\_\_
18. Has IGF-1 level decreased or normalized?  Yes  No

**SECTION B: Diagnosis Carcinoid tumor**

19. Is the patient experiencing carcinoid syndrome (e.g., episodic flushing, wheezing, diarrhea, eventual right-sided valvular heart disease)?  Yes  No
20. Has the patient had a surgery?  Yes  No *\*If No, skip to #22*
21. Has the patient had an inadequate response to surgery?  Yes  No
22. Is surgical treatment not a reasonable treatment option?  Yes  No
23. Is the patient currently receiving Sandostatin therapy for carcinoid tumors?  Yes  No  
**(Fax supporting documentation)**
24. If Yes, **Document evidence of symptom resolution:** \_\_\_\_\_

**SECTION C: Diagnosis Vasoactive intestinal peptide tumors (VIPomas)**

25. Is the patient experiencing severe watery diarrhea unresolved with use of antidiarrheal therapy?  
 Yes  No
26. Has the patient had a surgery?  Yes  No *\*If No, skip to #28*
27. Has the patient had an inadequate response to surgery?  Yes  No
28. Is surgical treatment not a reasonable treatment option?  Yes  No
29. Is the patient currently receiving Sandostatin therapy for VIPomas?  Yes  No  
**(Fax supporting documentation)**
30. If Yes, **Document evidence of symptom resolution:** \_\_\_\_\_

**\*\*NOTE: We can NOT make a decision without a copy of lab results - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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