# MEDICARE FORM
# Somatuline Depot (lanreotide), Lanreotide injection (Cipla) (lanreotide acetate injection) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Michigan MMP:**
**FAX:** 1-844-241-2495
**PHONE:** 1-855-676-5772

**For other lines of business:**
Please use other form.

**Note: Lanreotide (Cipla) is non-preferred. Sandostatin LAR and Somatuline Depot are preferred.**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | | |
| Address: | City: | State: | ZIP: | | |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider E-mail: | Office Contact Name: | Phone: | | | |

**Specialty** *(Check one):* ☐ **Oncologist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for:** ☐ **Somatuline Depot (lanreotide)** ☐ **Lanreotide Injection (Cipla)**
**Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**

**Note: Lanreotide (Cipla) is non-preferred. Sandostatin LAR and Somatuline Depot (lanreotide) are preferred.**

☐ Yes ☐ No Has the patient had prior therapy with Lanreotide (Cipla) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Sandostatin LAR (octreotide acetate) ☐ Somatuline Depot (lanreotide)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Sandostatin LAR (octreotide acetate) ☐ Somatuline Depot (lanreotide)

_____

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Acromegaly**
☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery or radiotherapy?
→ ☐ Yes ☐ No Is the clinical reason why the patient has not had surgery or radiotherapy?
Please indicate how the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender:
☐ IGF-1 level is higher than the laboratory's normal range
☐ IGF-1 level is lower than the laboratory's normal
☐ IGF-1 level falls within the laboratory's normal range

☐ **Carcinoid syndrome**
Please indicate which clinical setting the requested medication will be used:
☐ Single agent
☐ In combination with telotristat for persistent diarrhea due to poorly controlled carcinoid syndrome
☐ In combination with other systemic therapy options for persistent symptoms such as flushing or diarrhea, or for progressive disease
☐ Other

☐ **Primary gastrinoma, unresected**
☐ **Well-differentiated grade 3 Neuroendocrine tumors (NETs) with favorable biology, unresectable locally advanced or metastatic NETs with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)**
☐ **Neuroendocrine tumors of the gastrointestinal tract (carcinoid tumors), locoregional advanced or metastatic**
☐ **Neuroendocrine tumors of the thymus (carcinoid tumors), unresectable or metastatic**
☐ **Neuroendocrine tumors of the lung (carcinoid tumors), unresectable or metastatic**
☐ **Neuroendocrine tumors of the pancreas (islet cell tumors, including gastrinomas, glucagonomas, insulinomas and VIPomas)**
☐ **Gastroenteropancreatic neuroendocrine tumor, unresectable, well or moderately-differentiated, locally advanced or metastatic**
☐ **Pheochromocytoma, locally unresectable or metastatic**
☐ **Paraganglioma, locally unresectable or metastatic**
☐ **Zollinger-Ellison syndrome**
☐ **Other**

**For Continuation Requests (clinical documentation required for all requests):**

☐ **Acromegaly**
Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
☐ Increase ☐ Decreased or normalized ☐ No change

☐ **Carcinoid syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Zollinger-Ellison syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

**H. ACKNOWLEDGEMENT**

**Request Completed 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.

The plan may request additional information or clarification, if needed, to evaluate requests.