Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Octreotide

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Request Type:

☐ Initial - Go to 2 ☐ Continuation - Go to 15

Q2. Diagnosis:

☐ Acromegaly - Go to 3
☐ Neuroendocrine tumors (NETs) (injectable products only) - Go to 6
☐ Carcinoid syndrome (injectable products only)
☐ Vasoactive intestinal peptide tumors (VIPomas) (injectable products only) - Go to 7
☐ Pheochromocytoma and paraganglioma (injectable products only)
☐ Thymomas and thymic carcinomas (injectable products only)
☐ Inoperable bowel obstruction in cancer (injectable products only) - Go to 9
☐ Cancer-related diarrhea (injectable products only) - Go to 10
☐ Enterocutaneous fistula (injectable products only) - Go to 11
☐ Gastroesophageal varices (injectable products only) - Go to 12
☐ Pancreatic fistulas (injectable products only) - Go to 13
☐ Pituitary adenoma (injectable products only)
☐ Short bowel syndrome (injectable products only) - Go to 14

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Patient Name:	**Prescriber Name:**

☐ Congenital hyperinsulinism (CHI)/persistent hyperinsulinemic hypoglycemia of infancy (octreotide and Sandostatin only)

☐ AIDS-associated diarrhea (injectable products only) - Go to 8

☐ Zollinger-Ellison syndrome (injectable products only)

Q3. Patient has a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range.

☐ Yes ☐ No

Q4. Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the patient has not had surgery or radiotherapy. Must provide documentation.

☐ Yes ☐ No

Q5. For Mycapssa requests, patient has previously responded to and tolerated treatment with octreotide or lanreotide.

☐ Yes ☐ No

Q6. For Neuroendocrine tumors (NET), select all that apply.

☐ For treatment of NETs of the GI tract

☐ For treatment of NETs of the thymus

☐ For treatment of NETs of the lung

☐ For treatment of NETs of the pancreas, including gastrinomas, glucagonomas, and insulinomas.

☐ For treatment of well-differentiated grade 3 NETs with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging).

☐ For treatment of gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

Q7. For management of symptoms related to hormone hypersecretion of VIPomas.

☐ Yes ☐ No

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Q8. For treatment of AIDS-associated severe secretory diarrhea when anti-microbial (e.g., ciprofloxacin or metronidazole) or anti-motility agents (e.g., loperamide or diphenoxylate and atropine) have become ineffective.

☐ Yes ☐ No

Q9. For management of GI symptoms (e.g., nausea, pain, vomiting) of inoperable bowel obstruction in members with cancer.

☐ Yes ☐ No

Q10. For treatment of cancer-related diarrhea when the member has grade 3 or greater diarrhea according to National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE).

☐ Yes ☐ No

Q11. For management of volume depletion from enterocutaneous fistula.

☐ Yes ☐ No

Q12. For treatment of acute bleeding of gastroesophageal varices associated with cirrhosis.

☐ Yes ☐ No

Q13. For prevention and treatment of pancreatic fistulas following pancreatic surgery.

☐ Yes ☐ No

Q14. For treatment of short bowel syndrome when the daily intravenous fluid requirement is greater than 3 liters.

☐ Yes ☐ No

Q15. For acromegaly, the member's IGF-1 level has decreased or normalized since initiation of therapy.

☐ Yes ☐ No

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Q16. For NETs, Carcinoid syndrome, VIPomas, pheochromocytoma/paraganglioma, thymomas/thymic carcinomas, AIDS-associated diarrhea, bowel obstruction, cancer-related diarrhea, and Zollinger-Ellison syndrome (injectable products only): Patient is experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since initiation of therapy.

☐ Yes ☐ No

Q17. All other indications: Patient must meet all initial authorization criteria.

☐ Yes ☐ No

Q18. Requested Duration:

☐ 6 months ☐ 12 months ☐ Other

Q19. Additional Information:

_____ _____

Prescriber Signature Date

v2025