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

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

For Medicare Advantage Part B:
Phone: 1-866-503-0857 (TTY: 711)
FAX: 1-844-268-7263

For other lines of business:
Please use other form.

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

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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

E. PRODUCT INFORMATION

Request is for: ☐ **Somatuline Depot (lanreotide)** ☐ **Lanreotide injection (lanreotide acetate injection)**
Dose: _____ **Frequency:** _____
HCPCS Code: _____

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 Initial Requests:
Note: Lanreotide (Cipla) is non-preferred. The preferred products are Sandostatin LAR and Somatuline Depot.
☐ Yes ☐ No Has the patient had prior therapy with the requested product 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)

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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.

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

☐ **Acromegaly**
- ☐ Yes ☐ No Is this request for Lanreotide injection?
  - → ☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Sandostatin or Sandostatin LAR?
    - → ☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Somatuline?
- ☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery or radiotherapy?
  - → ☐ Yes ☐ No Is there a 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 compares 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 range
- ☐ IGF-1 level falls within the laboratory's normal range

☐ **Carcinoid syndrome**

☐ **Well-differentiated grade 3 Neuroendocrine tumors (NETs) (not of gastroenteropancreatic origin)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)**

☐ **Neuroendocrine tumors of the thymus (carcinoid tumors)**

☐ **Neuroendocrine tumors of the lung (carcinoid tumors)**

☐ **Neuroendocrine tumors of the pancreas (islet cell tumors, including gastrinomas, glucagonomas, insulinomas and VIPomas)**

☐ **Gastroenteropancreatic neuroendocrine tumor (GEP-NETs)**

☐ **Pheochromocytoma**

☐ **Paraganglioma**

☐ **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:
☐ Increased ☐ 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?

☐ **Neuroendocrine tumors (NETs):** ☐ **Well-differentiated grade 3 NETs with favorable biology** ☐ **NETs of gastrointestinal tract** ☐ **NETs of thymus** ☐ **NETs of lung** ☐ **NETs of pancreas** ☐ **Gastroenteropancreatic NETs (GEP-NETs)**

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

☐ **Pheochromocytoma/Paraganglioma**

☐ 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.