HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
SANDOSTATIN®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547.
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Sandostatin® (octreotide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ACROMEGALY			
1. Is the request for Acromegaly?	☐	☐	
2. Has the member had an inadequate response or contraindication to surgery or radiation?	☐	☐	**Please provide documentation**
METASTATIC CARCINOID TUMERS			
1. Is the request for metastatic carcinoid tumors?	☐	☐	
2. Does the member have severe diarrhea and flushing?	☐	☐	**Please provide documentation**
VASOACTIVE INTESTINAL PEPTIDE TUMOR (VIPoma)			
1. Is the request for Vasoactive Intestinal Peptide Tumor (VIPoma)?	☐	☐	
2. Does the member have profuse watery diarrhea?	☐	☐	**Please provide documentation**
HEYDE'S SYNDROME			
1. Is the request for gastrointestinal arteriovenous malformations (e.g. Heyde's Syndrome)?	☐	☐	
2. Has the member shown tolerance and efficacy to at least 1 week trial of short acting octreotide?	☐	☐	**Please provide documentation**
NEUROENDOCRINE TUMORS			
1. Is the request for neuroendocrine tumors?	☐	☐	

2. Is octreotide being used for disease control in the absence of symptoms?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with a clinically significant response to therapy?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM- 066
Origination Date: 01/11/2018
Reviewed/Revised Date: 02/20/2019
Next Review Date: 02/27/2020
Current Effective Date: 02/27/2019