Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS – FAMILY HEALTH PLAN

Octreotide (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Octreotide (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Octreotide

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 21.]

2. Does the patient have a diagnosis of acromegaly? Y N

   [If no, skip to question 9.]

3. Does the patient have persistent disease following pituitary surgery? Y N

   [If yes, skip to question 5.]

4. Is surgical resection not an option for this patient due to ONE of the following? A) Majority of tumor cannot be resected, B) Patient is a poor surgical candidate based on comorbidities, or C) Patient prefers medical treatment over surgery, or refuses surgery. Y N

[If no, then no further questions.]

5. Does the patient have a baseline IGF-1 level greater than or equal to 2 times the upper limit of normal (ULN) for age? Y N

   [If yes, then skip to question 8.]

6. Does the patient have a history of persistently elevated IGF-1 levels while on maximally tolerated doses of cabergoline for at least 6 months? Y N

   Provide IGF-1 level and date when patient was on cabergoline:

   _____

   [If yes, then skip to question 8.]

7. Was the patient unable to tolerate a trial of cabergoline or does the patient have ANY of the following contraindications to cabergoline? A) Uncontrolled hypertension, B) hypersensitivity to ergotamines, C) History of cardiac valve disorders, or D) History of pulmonary, pericardial, or retroperitoneal fibrotic disorders. Y N

   If yes, indicate which apply:

   _____

   [If no, then no further questions.]

8. Is octreotide prescribed by or in consultation with an endocrinologist? Y N

   [If no, then no further questions.]

   [If yes, skip to question 20.]

9. Does the patient have a diagnosis of carcinoid tumor or VIPomas? Y N

   [If no, skip to question 11.]

10. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

    [If yes, skip to question 20.]

    [If no, then no further questions.]

11. Does the patient have a diagnosis of hepatorenal syndrome? Y N

    [If no, skip to question 14.]

12. Is octreotide prescribed by a hepatologist or nephrologist? Y N

    [If no, then no further questions.]

13. Will octreotide be used in combination with midodrine and albumin? Y N

    [If no, then no further questions.]

    [If yes, skip to question 20.]

14. Does the patient have a diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)? Y N

    [If no, skip to question 17.]

15. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

    [If no, then no further questions.]

16. Did the patient have persistent disease after surgical resection, or is the patient not a candidate for surgery? Y N

[If no, then no further questions.]

[If yes, skip to question 20.]

17. Is the request for a pediatric patient with chemotherapy-induced diarrhea? Y N

    [If no, skip to question 19.]

18. Is octreotide prescribed by or in consultation with an oncologist or endocrinologist? Y N

    [No further questions.]

19. Does the patient have any of the following diagnoses? A) Dumping Syndrome, B) Short bowel syndrome with diarrhea, C) hyperthyroidism due to thyrotropinoma, D) Enterocutaneous fistula, or E) Portal hypertension and/or upper GI bleed related from esophageal varices Y N

    If yes, indicate which diagnosis:

    _____

    [If no, then no further questions.]

20. Is the patient at least 18 years of age? Y N

    [No further questions.]

21. Has the patient had a positive clinical response and/or symptom improvement since starting octreotide? Y N

    [If no, then no further questions.]

22. Is the patient's A1c and/or fasting glucose level controlled? Y N

    If no, submit documentation describing treatment plan to improve blood glucose:

    [If no, then no further questions.]

23. Does the patient have a diagnosis of acromegaly? Y N

    [If no, skip to question 25.]

24. Has the patient's IGF-1 level decreased or normalized since starting octreotide? Y N

    Please submit labs or document result and test date:

    _____

    [No further questions.]

25. Does the patient have a diagnosis of carcinoid tumor or VIPomas? Y N

Comments:

_____

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I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date