05/20/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Acromegaly Agents (IL88)

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 Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Acromegaly Agents (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Sandostatin LAR Depot (octreotide acetate)
Somatuline Depot (lanreotide acetate)
Somavert (pegvisomant)
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 15.]

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

   [If no, no further questions.]

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

   [If no, no further questions.]

4. Is the requested drug prescribed by an endocrinologist? Y N

   [If no, no further questions.]

5. Does the patient have a baseline IGF-1 level above normal for age? Y N

   [If no, no further questions.]

6. Is the request for Sandostatin LAR Depot? Y N

   [If no, skip to question 8.]

7. Has the patient had a trial and positive response to octreotide immediate-release injection? Y N

   [If no, no further questions.]

   [If yes, skip to question 9.]

8. Is the request for Somatuline Depot? Y N

   [If no, skip to question 12.]

9. Does the patient have a baseline IGF-1 level less than 2 times the upper limit of normal? Y N

   [If no, skip to question 11.]

10. Does the patient meet one of the following criteria? Y N

    Patient has failed a 6-month trial of cabergoline, or \
    Patient has a contraindication to cabergoline.

    [If no, no further questions.]

11. Does the patient meet one of the following criteria? Y N

    Inadequate response to surgery, or \ Surgical resection is not an option

    [No further questions.]

12. Is the request for Somavert? Y N

    [If no, no further questions.]

13. Does the patient have a normal baseline liver function test (LFT)? Y N

    [If no, no further questions.]

14. Has the patient had a trial and failure of, or contraindication to Sandostatin LAR Depot or Somatuline Depot? Y N

[No further questions.]

15. Does the patient have decreased or normalized IGF-1 levels? 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**