Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Somatuline Depot

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. Does the patient have Acromegaly?

☐ Yes - For Initial, go to 4. For Renewal, go to 11. ☐ No - Go to 2

Q2. Does the patient have Neuroendocrine tumors (NETs)?

☐ Yes - For Initial, go to 10. For Renewal, go to 12 ☐ No - Go to 3

Q3. Does the patient have carcinoid syndrome?

☐ Yes - For Initial, go to 13. For Renewal, go to 12. ☐ No - Go to 4.

Q4. Does the patient have pheochromocytoma and paraganglioma?

☐ Yes. If Initial, go to 13. If Renewal, go to 12. ☐ No. Go to 5.

Q5. Does the patient have Zollinger-Ellison syndrome?

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Patient Name:	**Prescriber Name:**

☐ Yes. For Initial, go to 13. For Renewal, go to 12. ☐ No.

Q6. Has the patient's IGF-1 level decreased or normalized since initiation of therapy (attach labs or chart notes to confirm)?

☐ Yes ☐ No

Q7. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ Yes ☐ No

Q8. Does the patient have a high pretreatment IGF-1 level for age and/or gender based on the laboratory reference range with laboratory report included?

☐ Yes ☐ No

Q9. Has the patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason why the member has not had surgery or radiotherapy (attach chart notes to confirm)?

☐ Yes ☐ No

Q10. Is the patient being treated for one of the following:
A) Gastrointestinal (GI) tract (carcinoid tumor) for treatment of NETs of the GI tract
B) Thymus (carcinoid tumor) for treatment of NETs of the thymus
C) Lung (carcinoid tumor) for treatment of NETs of the lung
D) Pancreas (islet cell tumors) for treatment of NETs of the pancreas, including gastrinomas, glucagonomas, insulinomas, and VIPomas.
E) Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
F) Well-differentiated grade 3 NETs not of gastroenteropancreatic origin) with favorable biology (e.g., relatively low Ki-67 [less than 55%], somatostatin receptor [SSR] positive imaging)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q11. Has the patient's IGF-1 level decreased or normalized since initiation of therapy (attach labs or chart notes to confirm)?

☐ Yes ☐ No

Q12. Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request