AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Somatostatin Analog Drugs (Medical)

Drug Requested: Check box below that applies.

❑ **lanreotide acetate extended release SQ injection 120 mg/0.5 mL (J1932)**	❑ **octreotide injection** (generic Sandostatin®) **(J2354)**
❑ **Sandostatin®** (octreotide) **injection (J2353)**	❑ **Signifor LAR®** (pasireotide) **SQ injection (J2502)**
❑ **Somatuline® Depot** (lanreotide) **injection 60 mg, 90 mg, 120 mg (J1930)**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Acromegaly (lanreotide, octreotide, Sandostatin, Signifor LAR, Somatuline)**

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older

AND

- ❑ Provider is an endocrinologist or neurosurgeon

AND

- ❑ Member has undergone pituitary surgery and/or irradiation is contraindicated **(chart notes must be submitted to document diagnosis and surgical history or contraindication to surgery)**

AND

- ❑ Diagnosis confirmed by elevated IGF-1 levels as well as inadequate suppression of growth hormone (GH) levels **(current labs must be submitted for documentation)**

AND

- ❑ **For Signifor LAR and Somatuline Depot**: Medication will not be used in combination with long-acting somatostatin analogs

❑ **Diagnosis: Acromegaly (lanreotide, octreotide, Sandostatin, Signifor LAR, Somatuline)**

Reauthorization: 12 months

- ❑ No toxicity has been observed while taking the requested medication

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AND

- ❑ Response is demonstrated by **BOTH** of the following **(Chart notes and current lab test results must be submitted for documentation**)
  - ❑ Reduction of GH levels from pre-treatment baseline
  - ❑ Normalization of IGF-1 level

❑ Diagnosis: Cushing's Disease (Signifor LAR)

Initial Authorization: 3 months

- ❑ Member is 18 years of age or older

AND

- ❑ Provider is an endocrinologist or neurosurgeon

AND

- ❑ Member has a diagnosis of Cushing's disease and pituitary surgery is not an option or has not been curative **(chart notes must be submitted to document diagnosis and surgical history or contraindication to surgery)**

AND

- ❑ Member's baseline 24-hour urinary free cortisol level is greater than 1.5 times the upper limit of normal **(labs must be submitted for documentation)**

AND

- ❑ Current baseline labs are attached documenting **ALL** the following: liver function tests, fasting plasma glucose, hemoglobin A1c, thyroid function, baseline ECG, and gallbladder ultrasound

❑ Diagnosis: Cushing's Disease (Signifor LAR)

Reauthorization: 12 months

- ❑ Member's current 24-hour urinary free cortisol level is below the upper limit of normal mean **(labs must be submitted for documentation)**

AND

- ❑ Current labs documenting member's liver function, fasting plasma glucose and hemoglobin A1c are attached

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AND

- ❑ Improvements in blood pressure, triglycerides, low-density lipoprotein cholesterol, weight and health related quality of life have been maintained while on Signifor therapy **(Chart notes must be submitted for documentation)**

❑ **Diagnosis: Other**
Please submit documentation showing medical necessity

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy & Therapeutic Committee:** 11/19/2020
REVISED/UPDATED/REFORMATTED: ~~4/1/2021; 6/14/2021; 10/11/2021; 4/7/2022; 4/26/2022; 6/15/2022; 12/7/2022, 11/18/2024; **12/20/2024;** 2/28/2025,~~ **12/30/2025**