# SENTARA HEALTH PLANS

## PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**The Sentara Health Plans Oncology Program is administered by OncoHealth**

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

# Somatostatin Analog Drugs (PHARMACY)

**Drug Requested:** (select drug below)

| | |
|---|---|
| ❑ **Bynfezia®** (octreotide) **SQ Injection** | ❑ **Mycapssa®** (octreotide) **Oral Tablet** |
| ❑ **Sandostatin® LAR Depot** (octreotide) | ❑ **Signifor®** (pasireotide) **SQ Injection** |
| ❑ **Somavert®** (pegvisomant) **Injection** | |

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

**Member Name:** _____

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

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

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

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

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

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

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

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**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 (Bynfezia, Sandostatin LAR, Somavert)

**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 levels as well as inadequate suppression of growth hormone (GH) levels **(labs must be submitted for documentation)**

**AND**

- ❑ **For Sandostatin LAR and Somavert**: Medication will not be used in combination with other short-acting somatostatin analogs

**AND**

- ❑ **For Somavert only**: Medication requires trial and failure of a long acting injectable octreotide product (e.g., Bynfezia, Sandostatin)

## ❑ Diagnosis: Acromegaly (Bynfezia, Sandostatin LAR, Somavert)

**Reauthorization: 12 months**

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

**AND**

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

**AND**

- ❑ **For Sandostatin LAR and Somavert:** Member has not had to use short-acting somatostatin therapy during treatment

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## ❑ Diagnosis: Acromegaly (Mycapssa)

**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 levels as well as inadequate suppression of growth hormone (GH) levels **(labs must be submitted for documentation)**

**AND**

- ❑ Member must be established on an injectable somatostatin analogue for ≥6 months with a stable dose for ≥3 months and has shown a clinical response

**AND**

- ❑ Medication will not be used in combination with other short-acting somatostatin analogs

**AND**

- ❑ There must be a documented medical necessity for use of oral capsules over injectable alternatives **(chart notes must be submitted to document contraindication to injectable therapy)**

## ❑ Diagnosis: Acromegaly (Mycapssa)

**Reauthorization: 12 months**

- ❑ Member has not had to use short-acting somatostatin therapy during treatment

**AND**

- ❑ No toxicity has been observed while taking Mycappsa

**AND**

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

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## ❑ Diagnosis – Cushing's Disease (Signifor SQ)

**Initial Authorization: 6 months**

- ❑ Member is 18 years of age or older

**AND**

- ❑ Provider is an endocrinologist or neurosurgeon

**AND**

- ❑ Member has 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 SQ)

**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

**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**

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**Medication being provided by Specialty Pharmacy – Proprium Rx**

***Not all drugs may be covered under every Plan***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

*****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.****