SENTARA COMMUNITY PLAN (MEDICAID)

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.

Somatostatin Analog Drugs (PHARMACY)

Drug Requested: (select drug below)

❑ **Bynfezia®** (octreotide) **SQ Injection**	❑ **lanreotide acetate extended release SQ injection 120 mg/0.5 mL**
❑ **Mycapssa®** (octreotide) **Oral Tablet**	❑ **octreotide injection** (generic Sandostatin®)
❑ **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 Name/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, lanreotide, octreoctide, 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, lanreotide, octreoctide, 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 Mycapssa

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 must be attached: 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.****

***Approved by Pharmacy and Therapeutics Committee:** 11/19/2021
REVISED/UPDATED/REFORMATTED: ~~4/1/2021; 6/14/2021; 10/11/2021;10/27/2021; 10/30/2021; 2/29/2024;~~ **2/28/2025**