maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Somavert

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Acromegaly (If checked, go to 2)

[] Treatment of excess growth hormone associated with McCune-Albright syndrome (MAS) (If checked, no further questions)

[] Other (If checked, no further questions)

2 Is this medication being prescribed by, or in consultation with, an endocrinologist? Yes No
[If no, no further questions.]

3 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?

If you have any questions, call: 1-888-258-8250

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	[] Initial (If checked, go to 4)		
	[] Continuation (If checked, go to 13)		
4	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
5	Has the patient had an inadequate response to surgery and/or radiotherapy? [If yes, skip to question 8.]	Yes	No
6	Is the patient an appropriate candidate for surgery and/or radiotherapy? [If no, skip to question 8.]	Yes	No
7	Is the patient experiencing negative effects due to tumor size (for example, optic nerve compression)? [If no, no further questions.]	Yes	No
8	Does the patient have a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level greater than 2 times the upper limit of normal (ULN) based on age and gender for the reporting laboratory? [NOTE: Pre-treatment (baseline) refers to the IGF-1 level prior to the initiation of any somatostatin analog (for example, Mycapssa (octreotide delayed-release capsules), an octreotide acetate injection product (for example, Bynfezia Pen, Sandostatin [generics], Sandostatin LAR Depot), Signifor LAR [pasireotide for injectable suspension], Somatuline Depot [lanreotide subcutaneous injection]), dopamine agonist (for example, cabergoline, bromocriptine), or Somavert (pegvisomant for injection). Reference ranges for IGF-1 vary among laboratories.] [If no, no further questions.]	Yes	No
9	Does the patient's insulin like growth factor-1 (IGF-1) remain elevated despite a 6 month trial of maximally tolerated dose of cabergoline? [If yes, skip to question 11.]	Yes	No
10	Does the patient have a contraindication or intolerance to cabergoline? [If no, no further questions.]	Yes	No
11	Has the patient tried and failed, or have an intolerance or contraindication to Sandostatin LAR? [If no, no further questions.]	Yes	No
12	Does the patient have baseline liver function tests (LFTs) that are LESS THAN 3 times the upper limit of normal? [No further questions.]	Yes	No
13	Has the patient responded to therapy with the requested medication, which is defined as having decreased or normalized insulin like growth factor-1 (IGF-1) levels? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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