Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Somatuline Depot 120 mg/0.5 mL subcutaneous syringe [ ] Somatuline Depot 60 mg/0.2 mL subcutaneous syringe [ ] Somatuline Depot 90 mg/0.3 mL subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Acromegaly

[ ] Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

[ ] Carcinoid syndrome

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Acromegaly

[ ] Unresectable, locally advanced gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

[ ] Metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

[ ] Carcinoid syndrome

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q5: Has the member had an inadequate response to surgery or radiotherapy? (Check only one that apply)

[ ] Yes (please specify start and end date(s) (month/year)) _____ (*Required)

[ ] No

Q6: Is the member not a candidate to surgery or radiotherapy? (Check only one that apply)

[ ] Yes (please specify start and end date(s) (month/year)) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q7: Is the requested medication prescribed by or in consultation with an endocrinologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q8: Is the requested medication prescribed by or in consultation with oncologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q9: Will the requested medication be used to reduce the frequency of short-acting somatostatin analog rescue therapy? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q10: Is the requested medication prescribed by or in consultation with an endocrinologist or oncologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q11: Request is for Lanreotide 120mg/0.5mL strength only? (Check only one that apply)

[ ] Yes

[ ] No(please provide clinical strength) _____(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	