State of Oklahoma
Oklahoma Health Care Authority

Lutathera® (Lutetium Lu 177 Dotatate) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Prescriber billing **(HCPCS code:**_____**)** ***Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ❑ **Gastroenteropancreatic Neuroendocrine (GEP-NET)**
     - A. Is diagnosis progressive locoregional advanced disease or metastatic disease? Yes☐ No☐
     - B. Is there positive imaging of somatostatin receptors? Yes☐ No☐
     - C. Will Lutathera® be used as second-line or subsequent therapy following progression on octreotide or lanreotide? Yes☐ No☐
     - D. Will Lutathera® be used as first-line for treatment of pheochromocytoma/paraganglioma? Yes☐ No☐

   - ❑ **If diagnosis is not listed above, please indicate diagnosis**:_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on Lutathera® ? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to Lutathera® therapy? Yes☐ No☐
   *If yes, please specify adverse reactions:*_____

Additional Information:_____

_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.