04/28/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Acromegaly Agents (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Acromegaly Agents (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Somavert (pegvisomant) Sandostatin LAR Depot (octreotide) Somatuline Depot (lanreotide)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If yes, skip to question 11.]

2. Is the patient greater than 18 years of age? Y N

   [If no, no further questions.]

3. Does the patient have a diagnosis of acromegaly? Y N

   [If no, no further questions.]

4. Is the requested drug prescribed by an endocrinologist? Y N

   [If no, no further questions.]

5. Does the patient have a documented baseline IGF-1 above normal for age? Y N

   [If no, no further questions.]

6. Has the patient had a trial and failure of, or contraindication to cabergoline? Y N

   NOTE: Typical response rate is ~50-60%. Can be used with cabergoline for improved response. Cabergoline monotherapy is considered first-line and ~1/3 of patients will respond. Response to cabergoline depends on baseline IGF-1.

   [If no, no further questions.]

7. Is the request for Somavert? Y N

   [If no, skip to question 9.]

8. Does the patient meet all of the following? Please list the medication tried and document failure/intolerance here: Y N

   _____

   Normal baseline LFTs \ Documented trial and failure of Sandostatin LAR Depot or Somatuline Depot

   [No further questions.]

9. Is the request for Sandostatin LAR? Y N

   [If no, no further questions.]

10. Has initial treatment with octreotide immediate release been shown to be effective and tolerated by the patient? Y N

    [No further questions.]

11. Has documentation to support normal IGF-1 levels been submitted? Y N

    [No further questions.]

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date