Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Somatuline Depot
(lanreotide acetate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Somatuline Depot:
☐ lanreotide injection (by Cipla J1930 or NDC 69097-0906-67)
☐ lanreotide injection (by Cipla J1932 or NDC 69097-0870-67)
☐ Lanreotide injection (by Exelan)
☐ Lanreotide injection (by Other or Unknown)

Strength & Dosing: ICD10:

Is this a new start or continuation of therapy**? ☐ new start of therapy ☐ continuation of therapy- start date:
If your patient has already begun treatment with drug samples, please choose "new start of therapy".

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:

☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

CPT Code(s):_____

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ acromegaly
☐ carcinoid syndrome
☐ neuroendocrine tumor (NET) of the Gastrointestinal tract, lung or thymus (Carcinoid Tumors)
☐ neuroendocrine tumor (NET) of the pancreas (includes insulinoma, glucagonoma gastrinomas, vasoactive intestinal peptides-secreting tumors VIPoma)
☐ pheochromocytoma or paraganglioma
☐ Other *(please specify)*:

Clinical Information:

(if carcinoid syndrome or NET) Is the medication being prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist? ☐ Yes ☐ No

(if pheochromocytoma or paraganglioma) Is the medication being prescribed by or in consultation with an endocrinologist, oncologist, or neurologist? ☐ Yes ☐ No

(if acromegaly) Has your patient had an inadequate response to surgery and/or radiotherapy? ☐ Yes ☐ No

(if acromegaly) Is your patient a candidate for surgery and/or radiotherapy? ☐ Yes ☐ No

(if acromegaly) Is the patient experiencing negative effects due to tumor size (for example, optic nerve compression)? ☐ Yes ☐ No

(if acromegaly) Does/Did the patient have a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory? Notes: 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 injection], Somatuline Depot [lanreotide injection], dopamine agonist [for example, cabergoline, bromocriptine], or Somavert [pegvisomant injection]). Reference ranges for IGF-1 vary among laboratories. ☐ Yes ☐ No

(if acromegaly) Is the medication being prescribed by, or in consultation with, an endocrinologist? ☐ Yes ☐ No

(if requesting lanreotide injection by Cipla J1932 or NDC 69097-0870-67) Has the patient tried Somatuline Depot or lanreotide acetate (by Cipla J1930 or NDC 69097-0906-67)? ☐ Yes ☐ No

(if yes) Is the patient unable to continue to use Somatuline Depot or lanreotide acetate (by Cipla J1930 or NDC 69097-0906-67) (the preferred medications) due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] that, according to the prescriber, would result in a significant allergy or serious adverse reaction? ☐ Yes ☐ No

Additional Pertinent Information: *(please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005