

# OCTREOTIDE (MEDICARE DETERMINATION)

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

**When this form is completed, please fax to Caremark at 1-888-836-0730.**

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

When conditions are met, we will authorize the coverage of Sandostatin LAR (Medicare Determination)

- Does the medication meet the Medicare definition of a drug or biological (e.g., the drug appears in the latest edition of the USP-NF or American Dental Association guide to dental therapeutics)?  Y  N
- Is this an injectable formulation of the drug?  Y  N
- Is the patient enrolled in Medicare Part B?  Y  N
- Has this drug claim been submitted through Medicare Part B?  Y  N
- Was the drug claim denied by Medicare Part B?  Y  N
- Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)?  Y  N

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**MedBlue RX<sup>SM</sup> and MedBlue RX Plus<sup>SM</sup>**

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|--|----------------------------|----------------------------|
| 7. Is the drug delivered through intravenous administration?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Is the drug administered through an implantable pump?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Is the drug administered through an external pump?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Is the drug included under a local coverage policy for the applicable Medicare DMERC?                | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Is the physician purchasing and providing the drug "incident to" physician services?                 | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 13. Does the patient have the diagnosis of a growth hormone deficiency?                                  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 14. Does the patient have the diagnosis of a carcinoid tumor?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 15. Does the patient have the diagnosis of vasoactive intestinal peptide tumors (VIPomas)?               | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 16. Did the patient initially try Sandostatin Injection (not the Depot form)?                            | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 17. Was the treatment with Sandostatin Injection effective and was it tolerated?                         | <input type="checkbox"/> Y | <input type="checkbox"/> N |

**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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