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)
☐ 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
☐ adrenal gland tumors
☐ carcinoid tumors
☐ gastroenteropancreatic neuroendocrine tumors (GEP- NETs)
☐ neuroendocrine tumor (NET) of the GI tract, lung or thymus
☐ neuroendocrine tumor (NET) of the pancreas (includes insulinoma, glucagonoma, vasoactive intestinal polypiptidoma or VIPoma)
☐ pheochromocytoma/paraganglioma
☐ Other *(please specify)*:

Clinical Information:

(if adrenal gland tumor) Did your patient undergo SRS (somatostatin receptor scintigraphy)? ☐ Yes ☐ No
(if yes) Were the results positive or negative? ☐ positive ☐ negative

(if adrenal gland tumor) What is the size of the tumor?
☐ 3 centimeters (cm) or less
☐ 4 or more centimeters (cm)
☐ unknown

(if adrenal gland tumor) Does your patient have non-adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome? ☐ Yes ☐ No

(if GEP-NETs) Does your patient have unresectable, locally advanced, or metastatic disease? ☐ Yes ☐ No

(if NET of GI tract, lung, or thymus) Is the neuroendocrine tumor unresectable or metastatic? ☐ 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? ☐ Yes ☐ No
(if acromegaly) Is the medication being prescribed by, or in consultation with, an endocrinologist? ☐ Yes ☐ No
(if acromegaly and requesting lanreotide injection by Cipla or by Other/Unknown) Has the patient tried Somatuline Depot? ☐ Yes ☐ No

(if yes) Is the patient unable to continue to use Somatuline Depot (the preferred medication) 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

(if pheochromocytoma/paraganglioma) Does your patient have locally unresectable disease? ☐ Yes ☐ No

(if Lanreotide injection by Cipla or by Other/Unknown and using for Neuroendocrine Tumor[s] [NETs] of the GI tract, lung, thymus [carcinoid tumors], and pancreas [including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors (VIPomas), insulinoma] or Pheochromocytoma/paraganglioma) The covered alternative is Somatuline Depot. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Lanreotide injection by Cipla or by Other/Unknown and using for Neuroendocrine Tumor[s] [NETs] of the GI tract, lung, thymus [carcinoid tumors], and pancreas [including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors (VIPomas), insulinoma] or Pheochromocytoma/paraganglioma) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

☐ The patient tried the alternative.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

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