



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Octreotide (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Octreotide (Medicare Determination).

Drug Name (select from list of drugs shown)

Octreotide Injection

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have the diagnosis of acromegaly?
[If the answer to this question is yes, then skip to question 5.] | Y | N |
| 3. Does the patient have the diagnosis of a carcinoid tumor?
[If the answer to this question is yes, then skip to question 5.] | Y | N |
| 4. Does the patient have the diagnosis of vasoactive intestinal peptide tumors (VIPomas)? | Y | N |
| 5. Will the thyroid-stimulating hormone (TSH) of the patient be monitored during Sandostatin therapy? | Y | N |

Comments: _____

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



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescriber (Or Authorized) Signature and Date