



Prior Authorization Form

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

**Drug Name (select from list of drugs shown)**  
Somatuline Depot 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 a diagnosis of acromegaly?  | Y | N |
| 3. Is surgery and/or radiotherapy a therapeutic option for the patient?<br>[If the answer to this question is no, then no further questions required.] | Y | N |
| 4. Has the patient had an inadequate response to surgery and/or radiotherapy?  | Y | N |

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

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

**Prescriber (Or Authorized) Signature and Date**