Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Octreotide

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for octreotide for reauthorization?

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response to octreotide?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of acromegaly?

☐ Yes ☐ No

Q4. Is baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender above the upper limit of normal based on laboratory reference range?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response to surgery or radiation therapy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is there a clinical reason why the patient has not had surgery or radiation therapy?

☐ Yes ☐ No

Q7. Does the patient have a documented diagnosis of metastatic carcinoid tumor?

☐ Yes ☐ No

Q8. Does the patient require symptomatic treatment of severe diarrhea or flushing episodes?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea?

☐ Yes ☐ No

Q10. Is octreotide being prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 6 months ☐ 12 months ☐ Other

Q12. Additional Information:

_____ _____

Prescriber Signature Date

v2025