Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Lanreotide Extended Release

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of acromegaly? If YES, go to 4. If NO, go to 7.

☐ 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? If YES, go to 9. If NO, go to 6.

☐ Yes ☐ No

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Lanreotide Extended Release

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**

Q6. Is there a clinical reason why the patient has not had surgery or radiation therapy? If YES, go to 9.

☐ Yes ☐ No

Q7. Does the patient have a documented diagnosis of unresectable, well or moderately differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors? If YES, go to 9. If NO, go to 8.

☐ Yes ☐ No

Q8. Does the patient have a documented diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea?

☐ Yes ☐ No

Q9. Is octreotide being prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist?

☐ Yes ☐ No

Q10. Requested Duration

☐ 12 months ☐ Other

Q11. Additional Information

Prescriber Signature Date

v2026