



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Octreotide - Medicare

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: <input type="checkbox"/> 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 for IV administration and covered under Medicare Part B?

☐ Yes

☐ No

Q2. Is the request for octreotide for reauthorization? If YES, go to 3. If NO, go to 4.

☐ Yes

☐ No

Q3. Has the patient had a positive clinical response to octreotide?

☐ Yes

☐ No

Q4. Does the patient have a documented diagnosis of acromegaly? If YES, go to 5. If NO, go to 8.

☐ Yes

☐ No

Q5. 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? If YES, go to 6.

☐ Yes

☐ No



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Member Name:	Prescriber Name:
Q6. Has the patient had an inadequate response to surgery or radiation therapy? If YES, go to 12. If NO, go to 7.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is there a clinical reason why the patient has not had surgery or radiation therapy? If YES, go to 12.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have a documented diagnosis of metastatic carcinoid tumor? If YES, go to 9. If NO, go to 10.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Does the patient require symptomatic treatment of severe diarrhea or flushing episodes? If YES, go to 12.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does the patient have a diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea? If YES, go to 12. If NO, go to 11.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is octreotide being used for a medically accepted indication not otherwise excluded from Medicare Part D? If YES, go to 12.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Is octreotide being prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Requested Duration:	
<input type="checkbox"/> 12 Months <input type="checkbox"/> Other	
Q14. Additional Information:	



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Member Name:

Prescriber Name:

Prescriber Signature

Date

v2026