CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Somavert®– Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

1. What drug is being prescribed? ☐ Somavert® ☐ Other ____________________________________

2. What is the patient's diagnosis? ☐ Acromegaly ☐ Other ____________________________________

3. What is the ICD code? _________________

4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #7.

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

6. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #7 and complete this form in its entirety.

7. Does the patient have clinical evidence of acromegaly (e.g., frontal bossing, course facial features, thick lips, protruding jaw with widely spaced teeth, large hands and feet)? ☐ Yes ☐ No

8. Is the patient currently on Somavert®? *If Yes, skip to #15* ☐ Yes ☐ No

9. What is the ***pretreatment*** IGF-1 level? _________________

10. Does the patient have a documented high IGF-1 level for age/gender? ☐ Yes ☐ No

11. Has the patient had an inadequate or partial response to surgery or radiotherapy?
    If Yes, skip to #13 ☐ Yes ☐ No

12. What is the clinical reason for not having surgery or radiotherapy? ***If Yes, indicate below*** ☐ Yes ☐ No
    ☐ Patient is medically unstable (poor surgical candidate)
    ☐ Patient is at high risk for complications of anesthesia because of airway difficulties
    ☐ Patient has major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes
    ☐ Patient refuses surgery or prefers the medical option over surgery
    ☐ Lack of an available skilled surgeon
    ☐ Other ____

13. Has the patient had an inadequate or partial response to octreotide (Sandostatin®) or lanreotide (Somatuline Depot®)? *If Yes, no further questions* ☐ Yes ☐ No

14. Does the patient have an intolerance or contraindication to octreotide (Sandostatin®) or lanreotide (Somatuline Depot®)? ☐ Yes ☐ No

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Complete the following questions if the patient is currently on Somavert

15. What is the ***current*** IGF-1 level? _________________

16. Has the IGF-1 level decreased or normalized? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

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