Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

SANDOSTATIN LAR DEPOT (Octreotide)

Coverage Criteria
Acromegaly, Carcinoid Tumor, Vasoactive Intestinal Peptide Tumors (VIPomas)

Required Medical Information
Patient had prior therapy with Sandostatin Injection (not Depot form), and treatment was effective and tolerated.

Exclusion Criteria
Non FDA approved treatment

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		**Male**		**Female**	
Date of Birth		**Age**		**Weight in Kg**	
Street Address					
City		**State**		**Zip**	

Physician Information					
Name					
Agent		**Contact Name**			
Specialty/Office					
Clinic Name					
Street Address					
City		**State**		**Zip**	
Phone		**Fax**			

Requested Drug		
SANDOSTATIN LAR DEPOT	**Reason for Request**	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request				
Labs: Baseline/Ongoing	**Strength/Dosage**			
Formulary Alternative(s) Attempted?	**Yes:**		**No:**	
Please List Alternative Formulary Drugs				
Comments				

Physician Signature: ________________________________ **Fax Form to 1-877-847-9904**