



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

SOMATULINE DEPOT (Lanreotide)

Coverage Criteria

Acromegaly

Required Medical Information

Either surgery and/or radiotherapy are not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy.

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			

SOMATULINE 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				
----------	--	--	--	--

Physicians Signature: _____ Fax Form to 1-877-847-9904