



**Prescription Drug Coverage Determination Form**

Somatostatin

Octreotide acetate injection

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

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| <p><b>Prior Authorization Criteria:</b></p> <p>1. Does the patient have a diagnosis of acromegaly, carcinoid tumor, or vasoactive intestinal peptide tumor (VIPomas)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">Date of Diagnosis: _____ ICD-9 Code: _____</p> |
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Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.