Prior Authorization Request Form for octreotide **(Mycapssa)**

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. For which indication or diagnosis is the requested medication being prescribed? **Note: Non-FDA-approved uses are NOT approved including vasoactive intestinal peptide tumors (VIPomas) and carcinoid tumors.**	☐ Acromegaly - Proceed to Question **2** ☐ Other - **STOP Coverage not approved**	
2. Is the requested medication prescribed by or in consultation with an endocrinologist?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient tried an injectable formulation of octreotide (for example, Sandostatin generics, Sandostatin LAR Depot, Bynfezia)?	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient failed octreotide therapy due to lack of response?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ______________

Prescriber Signature Date

[10 February 2021]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: