AmWINS Rx

Date of Request:____________________

Sterling Retiree Rx Prior Authorization Form

SANDOSTATIN LAR DEPOT (Octreotide)

Coverage Criteria
Diagnosis is Acromegaly **or** severe diarrhea/flushing episodes associated with Metastatic Carcinoid Tumors **or** profuse watery diarrhea associated with VIP-Secreting Tumors.

Prior Sandostatin Inj. therapy (not depot form) effective and tolerated for at least 2 weeks.

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 1-866-481-3704**