



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### SOMATULINE DEPOT (Lanreotide)

#### Coverage Criteria / Required Medical Information

Long-term treatment of Acromegaly **and** 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.

#### 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				
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Physicians Signature: \_\_\_\_\_ Fax Form to 1-866-481-3704