



**Prescription Drug Coverage Determination Form**  
Somatostatin  
Somatuline Depot® (Lanreotide Acetate)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-466-9854.

**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: \_\_\_\_\_

<b>Prior Authorization Criteria:</b>		
1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? Diagnosis: _____ ICD-9 code _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is surgery and/or radiation therapy an option for this patient? If yes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the patient had an inadequate response?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.