P.O Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Somavert™ and Somatuline®
(Pegvisomant and lanreotide)

Therapeutic use: Treatment of acromegaly in patients who have had an inadequate response to surgery and/or radiation therapy and/or other medical therapies
Quantity Limit: N/A
Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐☐☐☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐☐☐☐☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Medication Requested: Somavert ❑ Somatuline ❑

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with acromegaly?	❑ Yes	❑ No
2.	Is the prescribing physician an endocrinologist or has an endocrinologist been consulted?	❑ Yes	❑ No
3.	Has the patient had surgical resection of the pituitary gland?	❑ Yes	❑ No
4.	Please provide information in the table below about medications the patient has tried (bromocriptine, cabergoline, octreotide).		
5.	Is the patient a candidate for surgery/radiation or drug therapy? If no, please explain:_____	❑ Yes	❑ No

Medication(s) Tried	Duration of Therapy	Reason(s) for Discontinuation
a.		
b.		
c.		

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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