PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Lutathera® (lutetium Lu 177 dotatate)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Lutathera 7.4 GBq (200 mCi) vial for inj.

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Weight (if applicable):_____

Place of administration: ☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing: ☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Note: Lutathera must be given with long-acting octreotide 30mg intramuscularly every 4 weeks.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018

Last reviewed 01/2021

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of metastatic or locally advanced somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumor (GEP-NET) including foregut, midgut, and hindgut NETs. Must have progressive tumor despite standard-dose long-acting somatostatin analog therapy [i.e., Sandostatin LAR Depot (octreotide injection) 30mg IM monthly and Somatuline® Depot (lanreotide injection) 120mg deep SQ monthly].
2. Age 18 years or older.
3. Karnofsky performance-status score of at least 60 (scale from 0 to 100).

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Metastatic or locally advanced somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumor (GEP-NET) including foregut, midgut, and hindgut NETs (provide supporting documentation).
- ☐ *Other – the patient's condition is:* _____

B. Does the patient have a progressive tumor despite standard-dose long-acting somatostatin analog therapy?

- ☐ Yes, list agent: _____
- ☐ No, rationale: _____

C. What is the patient's Karnofsky performance-status score? _____

Additional information

If authorized for treatment, Lutathera is limited to the following: 7.4 GBq (200 mCi) every 8 weeks for a total of 4 doses.

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Last reviewed 01/2021