FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

# Xermelo® Coverage Determination Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name:<br>Select one of the following:<br>❑ Request is for **GENERIC**<br>❑ Request is for **BRAND** (unable to take the generic) | Strength: | Dosage Form: |
| ❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Select the Type(s) of Coverage Determination Requested:**

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

**Select the diagnosis below:**

❑ Carcinoid syndrome diarrhea

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Prescriber's Specialty:**

Select if the requested medication is prescribed by or in consultation with one of the following specialists:

❑ Endocrinologist ❑ Gastroenterologist ❑ Oncologist

**Medication History:**

Select if the patient has had a history of trial and failure, or intolerance to the following:

❑ Octreotide acetate

❑ Somatuline Depot

❑ Other drugs in the same class. Please specify: _____

❑ Other therapeutic equivalent alternatives. Please specify: _____

**Clinical Information:**

Is the patient's diarrhea adequately controlled by a stable dose of somatostatin analog (SSA) therapy [e.g., octreotide (Sandostatin, Sandostatin LAR), lanreotide (Somatuline Depot)] for at least 3 months? ❑ **Yes** ❑ **No**

Will the patient use Xermelo in combination with SSA therapy? ❑ **Yes** ❑ **No**

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Xermelo therapy? ❑ **Yes** ❑ **No**

Will the patient continue to use Xermelo in combination with SSA therapy(e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot])? ❑ **Yes** ❑ **No**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.