



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

Xermelo® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Carcinoid syndrome diarrhea	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Prescriber's specialty:	
Select if Xermelo is prescribed by or in consultation with one of the following specialists:	
<input type="checkbox"/> Oncologist	
<input type="checkbox"/> Endocrinologist	
<input type="checkbox"/> Gastroenterologist	
Clinical Information:	
Is patient's diarrhea inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the patient use Xermelo in combination with SSA therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot])? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
Will the patient continue to use Xermelo in combination with SSA therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot])? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation of patient's positive clinical response to Xermelo therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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.