

Lutathera® (Lutetium Lu-177 Dotatate) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Prescriber billing (HCPCS code: _____) Start Date (or date of next dose): _____
Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____
Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____
Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
- ☐ **Gastroenteropancreatic Neuroendocrine (GEP-NET)**

A. Is diagnosis progressive locoregional advanced disease or metastatic disease? Yes____ No____
B. Is there positive imaging of somatostatin receptors? Yes____ No____
C. Will Lutathera® be used as second-line or subsequent therapy following progression on octreotide or lanreotide? Yes____ No____
D. Will Lutathera® be used as first-line for treatment of pheochromocytoma/paraganglioma? Yes____ No____
- ☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on Lutathera®? Yes____ No____
3. Has the member experienced any adverse drug reactions related to Lutathera® therapy? Yes____ No____
If yes, please specify adverse reactions: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</p>
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