pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XERMELO (telotristat ethyl) PRIOR AUTHORIZATION FORM

Xermelo and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are available on the Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Xermelo tablet*	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx codes (*required*):	

***Specialty Pharmacy Drug Program:** Xermelo is part of the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – Diplomat Specialty Pharmacy.

ALL requests		
1. Is Xermelo being prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist?	☐Yes ☐No	*If prescriber is not a specialist, submit documentation of consultation with a specialist.*
2. Will the recipient use Xermelo in combination with somatostatin analog therapy (eg, Sandostatin/octreotide, Somatuline/lanreotide)?	☐Yes ☐No	*Submit documentation.*
INITIAL requests		
1. Is the recipient being treated for a diagnosis of carcinoid syndrome diarrhea?	☐Yes – *Submit documentation supporting recipient's diagnosis.* ☐No – *Submit medical literature documentation supporting the use of Xermelo for the recipient's diagnosis.*	
2. Is the recipient's diarrhea inadequately controlled by somatostatin analog therapy (eg, Sandostatin/octreotide, Somatuline/lanreotide)?	☐Yes ☐No	*Submit documentation of medications tried, including dose and duration of therapy.*
RENEWAL requests		
1. Since starting Xermelo, did the recipient experience symptom improvement?	☐Yes ☐No	*Submit documentation of recipient's response to therapy.*
2. Does the recipient have any signs of severe constipation and/or severe persistent or worsening abdominal pain?	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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