

State of Oklahoma

OKLAHOMA Health Care Authority Lutathera® (Lutetium Lu-177 Dotatate) Prior Authorization Form

Member Name:	Date of Birth:	Member ID#:
	Drug Information	n
Prescriber billing (HCPCS code:	ode:) 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 a	ahovo ploaco indicato diac	unosis:
☐ If diagnosis is not listed above, please indicate diagnosis:		
Additional information.		
For Continued Authorization:		
	of progressive disease while	on Lutathora® 2 Vos. No.
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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

processing delays.

University of Oklahoma College of Pharmacy **Pharmacy Management Consultants** Product Based Prior Authorization Unit

> Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4

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Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in