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

Prior authorization guidelines for **Xermelo (telotristat ethyl)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Xermelo tablet		Strength:	
Dose/directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx codes (*required*):	
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.*	
Will the beneficiary use Xermelo in combination with somatostatin analog therapy (eg, Sandostatin/octreotide, Somatuline/lanreotide)?	☐Yes ☐No	*Submit documentation.*	
INITIAL requests			
Is the beneficiary being treated for a diagnosis of carcinoid syndrome diarrhea?	☐Yes – *Submit documentation supporting beneficiary's diagnosis.* ☐No – *Submit medical literature documentation supporting the use of Xermelo for the beneficiary's diagnosis.*		
Is the beneficiary'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			
Since starting Xermelo, did the beneficiary experience symptom improvement?	☐Yes ☐No	*Submit documentation of beneficiary's response to therapy.*	
Does the beneficiary 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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