



Signifor (pasireotide) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy, Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:	State:	ZIP:
Home Phone:		Work Phone:		Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs				Patient Height: _____ inches or _____ cms	Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group #: _____		If yes, provide ID#: _____		Carrier Name: _____	
Insured:		Insured:			
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:			Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:			City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:		
Provider Email:			Office Contact Name:		Phone:		
Specialty (Check one): <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Other: _____							

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____				Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____			
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E. PRODUCT INFORMATION

Request is for: Signifor (pasireotide)
Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code : _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):
Cushing's syndrome/disease
 Yes No Does the patient have a pretreatment urinary free cortisol level?
↳ Please indicate the pretreatment urinary free cortisol level: _____
 Yes No Did the patient have surgery that was not curative?
↳ Yes No Is the patient a candidate for surgery?
For Continuation Requests (clinical documentation required for all requests):
 Yes No Has the patient experienced a reduction in urinary free cortisol levels or improvement in signs or symptoms of the disease since starting therapy?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ Date: ____ / ____ / ____
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.