Signifor (pasireotide) Medication Precertification Request

(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 #: ____________________
Group #: ____________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**: ____________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: ____________
Address: ____________
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________

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 ☐ Unknown Does the patient have a pretreatment urinary free cortisol level?
→ ☐ Yes ☐ No Does the patient have a condition (e.g., renal insufficiency/failure, adrenal incidentaloma) in which a urinary free cortisol level is not an appropriate measure of the patient's cortisol level?
☐ Yes ☐ No ☐ Unknown Does the patient have a pretreatment cortisol level as indicated by one of the following tests? ☐ Late-night salivary cortisol
☐ 1 mg overnight dexamethasone suppression test (DST)
☐ Low dose DST (2mg per day for 48 hours)

☐ Yes ☐ No Did the patient have surgery that was not curative?
→ ☐ Yes ☐ No Is the patient a candidate for surgery?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No ☐ Unknown Has the patient experienced a reduction in urinary free cortisol levels since the start of therapy with the requested medication?

→ ☐ Yes ☐ No Does the patient have a condition (e.g., renal insufficiency/failure, adrenal incidentaloma) in which a urinary free cortisol level is not an appropriate measure of the patient's cortisol level?

☐ Yes ☐ No ☐ Unknown Has the patient experienced a reduction in cortisol level since the start of therapy with the requested medication as indicated by one of the following tests?

- ☐ Late-night salivary cortisol
- ☐ 1 mg overnight dexamethasone suppression test (DST)
- ☐ Low dose DST (2mg per day for 48 hours)

☐ Yes ☐ No Has the patient had an improvement of signs and symptoms of the disease since the start of therapy with the requested medication?

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.