Signifor LAR (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 LAR (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):

☐ **Acromegaly**

Please indicate the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compared to the laboratory's reference normal range based on age and/or gender: ☐ IGF-1 level is higher than the laboratory's normal range ☐ IGF-1 level is lower than the laboratory's normal range
☐ IGF-1 level falls within the laboratory's normal range

☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery?
→ ☐ Yes ☐ No Is there a clinical reason why the patient has not had surgery?
☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Sandostatin or Sandostatin LAR?
☐ Yes ☐ No Has the patient had an ineffective response, contraindication or intolerance to Somatuline?

☐ **Cushing's syndrome/disease**

☐ 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):

☐ **Acromegaly only:**

Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:
☐ IGF-1 level has increased ☐ IGF-1 level has decreased or normalized ☐ IGF-1 level has not changed

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.