Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Signifor LAR
(pasireotide pamoate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)* ICD10:

☐ Signifor LAR 10mg powder for injection
☐ Signifor LAR 20mg powder for injection
☐ Signifor LAR 30mg powder for injection
☐ Signifor LAR 40mg powder for injection
☐ Signifor LAR 50mg powder for injection
☐ Signifor LAR 60mg powder for injection

Strength and Dosing:

Is this a new start or continuation of therapy**? ☐ new start of therapy ☐ continued therapy- start date:
If your patient has already begun treatment with drug samples, please choose "new start of therapy".

(If continued therapy) Is there documentation of beneficial response to this medication in your patient? Yes ☐ ☐ No ☐ Unknown

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

***Cigna's nationally preferred specialty pharmacy*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Please indicate the condition Signifor LAR is being used to treat and answer additional questions as necessary.

	Acromegaly		
☐	Additional Questions:	Which of these best describes your patient? ☐ patient previously had surgery and/or radiotherapy, but response was inadequate ☐ surgery and/or radiotherapy is NOT an option ☐ patient is experiencing negative side effects due to tumor size (for example, optic nerve compression) ☐ none of the above (If none of the above) What is the clinical rationale for the use of Signifor LAR in your patient?	

		Before starting any somatostatin analog, was your patient's insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory? Has the patient tried and had inadequate efficacy to Somatuline Depot? (If no/unknown) Does your patient have a contraindication according to FDA label, significant intolerance, or is not a candidate for Somatuline Depot? [not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], other attributes/conditions, or is unable to administer and requires this dosage formulation]	☐ Yes ☐ No ☐ Unknown ☐ Yes ☐ No ☐ Unknown
	Cushing's Disease		
☐	Additional Questions:	Which of these best describes your patient? ☐ patient is not a candidate for surgery ☐ surgery has not been curative for this patient ☐ patient is awaiting surgery ☐ patient is awaiting therapeutic response after radiotherapy ☐ none of the above	
	Cushing's Syndrome		
☐	Additional Questions:	Which of these best describes your patient? ☐ patient is awaiting surgery ☐ patient is awaiting therapeutic response after radiotherapy ☐ none of the above	
☐	Other Diagnosis: (please specify)		

Duration of therapy:

Alternatives tried: (*please include length of trial and/or if samples were given)*

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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