Signifor® LAR (pasireotide) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B: Please Use Medicare Request Form

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):

☐ **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 disease**
☐ Yes ☐ No ☐ Unknown Does the patient have a pretreatment cortisol level as indicated by one of the following tests?
→ ☐ Urinary free cortisol (UFC) level
☐ Late-night salivary cortisol
☐ 1 mg overnight dexamethasone suppression test (DST)
☐ Longer, low dose DS (2 mg 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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For Medicare Advantage Part B: Please Use Medical Request Form

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):

☐ **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

☐ **Cushing's disease only:**

☐ 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?

- ☐ Urinary free cortisol (UFC) level
- ☐ Late-night salivary cortisol
- ☐ 1 mg overnight dexamethasone suppression test (DST)
- ☐ Longer, low dose DS (2 mg per day for 48 hours)

☐ 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?

☐ 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.