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 with the requested medication**? If patient has been taking samples, please pick "new start."
☐ new start ☐ continuation of therapy

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other (please specify):
CPT Code(s): _____
☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

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 the patient? ☐ Patient had an inadequate response to surgery and/or radiotherapy ☐ Patient is not an appropriate candidate for surgery and/or radiotherapy ☐ Patient is experiencing negative side effects due to tumor size (for example, optic nerve compression) ☐ None of the above	
		Does the patient have a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory? Please Note: Pre-treatment (baseline) refers to the IGF-1 level prior to the initiation of any somatostatin analog (for example, Mycapssa (octreotide delayed-release capsules), an octreotide acetate injection product (for example, Bynfezia Pen, Sandostatin [generics], Sandostatin LAR Depot), Signifor LAR [pasireotide for injectable suspension], Somatuline Depot [lanreotide subcutaneous injection]), dopamine agonist (for example, cabergoline, bromocriptine), or Somavert (pegvisomant for injection). Reference ranges for IGF-1 vary among laboratories.	☐ Yes ☐ No
		Is the requested medication being prescribed by, or in consultation with, an endocrinologist?	☐ Yes ☐ No
		Has the patient tried ONE of octreotide ER injectable suspension (Sandostatin LAR Depot, generic), Somatuline Depot or lanreotide subcutaneous injection [may require prior authorization]? Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67.	☐ Yes ☐ No
		Is each prescribed dose 60 mg or less administered intramuscularly no more frequently than once every 28 days?	☐ Yes ☐ No
	Cushing's Disease		
☐	Additional Questions:	Is the patient currently receiving Signifor LAR/Signifor?	☐ Yes ☐ No
		(if currently receiving) Has the patient responded to Signifor/Signifor LAR, as determined by the prescriber? Note: An example of patient response is decrease in the mean urinary free cortisol level.	☐ Yes ☐ No
		(if not currently receiving) According to the prescriber, is the patient a candidate for surgery or has surgery been curative? Note: For patients with Cushing's disease/syndrome awaiting surgery, refer to endogenous Cushing's Syndrome criterion.	☐ Yes ☐ No
		(if not currently receiving) Is the requested medication being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of Cushing's disease?	☐ Yes ☐ No
		(if not currently receiving) Is each prescribed dose 40 mg or less administered intramuscularly no more frequently than once every 28 days?	☐ Yes ☐ No

	Endogenous Cushing's Syndrome		
☐	Additional Questions:	Which of these best describes the patient? ☐ According to the prescriber, patient is not a candidate for surgery or surgery has not been curative ☐ Patient is awaiting surgery for Endogenous Cushing's syndrome ☐ Patient is awaiting therapeutic response after radiotherapy for Endogenous Cushing's syndrome ☐ None of the above Is this medication being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome? Is each prescribed dose 40 mg or less administered intramuscularly no more frequently than once every 28 days?	☐ Yes ☐ No ☐ Yes ☐ No
☐	Other Diagnosis: (please specify)		

Duration of therapy:

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

Additional pertinent information:

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:**_____

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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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