

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: **Commercial (Traditional)** **Commercial (Individual/Optimized)**

Medicaid

This request is: **Urgent** (life threatening) **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signifor LAR[®] (pasireotide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

New Request Continuation Request

Drug product: Signifor LAR 20 mg
 Signifor LAR 40 mg
 Signifor LAR 60 mg

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose: _____ **Dose Frequency:** _____

Place of administration: Physician's office

Outpatient infusion

Facility: _____ NPI: _____ Fax: _____

Home infusion

Agency: _____ NPI: _____ Fax: _____

Billing: Physician to buy and bill

Facility to buy and bill

Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for treatment of acromegaly
2. Must have inadequate response to surgery, unless surgery is not an option
3. Must first try Sandostatin LAR

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Acromegaly
 Other – rationale for use: _____

B. What was the date of the patient's surgery?

- Date: _____
 The patient did not have surgery
 Surgery is not an option because: _____

C. Has the patient tried Sandostatin LAR?

- Yes, the dates Sandostatin LAR was used are: _____
 No, because: _____