HEALTHY U CHIP

# PRIOR AUTHORIZATION REQUEST FORM
## SIGNIFOR®

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | HCPCS Code: |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being requested:** ☐ Signifor® (pasireotide)

Dosing/Frequency:_____

| **If the request is for reauthorization, proceed to reauthorization section.** | | | |
|---|---|---|---|
| **Questions** | **Yes** | **No** | **Comments/Notes** |
| 1. Is the prescribing provider an endocrinologist? | ☐ | ☐ | |
| 2. Does the member have a confirmed diagnosis of persistent or recurrent Cushing's disease evidenced by at least three 24-hour mean urinary free cortisol (mUFC) > 1.5 times the upper of normal (ULN)? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the member shown symptoms of Cushing's Disease, such as diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression and/or anxiety? | ☐ | ☐ | **Please provide documentation** |
| 4. Is the member a candidate for pituitary surgery? | ☐ | ☐ | **Please provide documentation** |
| 5. If the member has had pituitary surgery, was it NOT curative? | ☐ | ☐ | **Please provide documentation** |
| 6. Has the member tried and failed, or has a contraindication/intolerance, to at least two of the following: ketoconazole, Metopirone (metyrapone), Lysodren (mitotane), cabergoline? | ☐ | ☐ | **Please provide documentation** |
| **REAUTHORIZATION** | | | |
| 1. Is the requesting for reauthorization of therapy? | ☐ | ☐ | |
| 2. Does updated clinical documentation show stabilization of disease or absence of disease progression? | ☐ | ☐ | **Please provide documentation** |
| 3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal or a decrease by 50% from baseline? | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| 4. Does the member have an absence of unacceptable drug toxicity? | ☐ | ☐ | |

**What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.**

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-109
Origination Date: 07/01/2024
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

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