

HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

SIGNIFOR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member a candidate for pituitary surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. If the member has had pituitary surgery, was it NOT curative?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the requesting for reauthorization of therapy?	Yes	No	
2. Does updated clinical documentation show stabilization of disease or absence of disease progression?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

4. Does the member have an absence of unacceptable drug toxicity?	<input type="checkbox"/>	<input type="checkbox"/>	
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:			

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Policy: PHARM-HU-109
 Origination Date: 01/01/2022
 Reviewed/Revised Date: 01/18/2023
 Next Review Date: 01/18/2024
 Current Effective Date: 02/01/2023

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