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 your 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 (If none of the above) What is the clinical rationale for the use of Signifor LAR in your patient?	
		Before starting any therapy for this diagnosis (pre-treatment, baseline), was your patient's insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory? Note: Pre-treatment [baseline] refers to the IGF-1 level prior to starting any somatostatin analog (for example, Mycapssa [octreotide delayed-release capsules], an octreotide acetate injection product [for example, Bynfezia Pen, Sandostatin (generic), Sandostatin LAR Depot], Signifor LAR [pasireotide injection], Somatuline Depot [lanreotide injection], dopamine agonist [for example, cabergoline, bromocriptine], or Somavert [pegvisomant injection]). Reference ranges for IGF-1 vary among laboratories.	☐ Yes ☐ No
		Is this medication being prescribed by, or in consultation with, an endocrinologist?	☐ Yes ☐ No
		Has the patient tried Somatuline Depot (lanreotide acetate) injection?	☐ Yes ☐ No
	Cushing's Disease		
☐	Additional Questions:	Is this initial therapy or is the patient currently receiving this medication? If patient has been taking samples, please pick "initial therapy."	☐ Initial therapy ☐ Currently receiving
		(if currently receiving) Has the prescriber determined that the patient has responded to this medication (for example, decrease in the mean urinary free cortisol level)?	☐ Yes ☐ No
		Which of these best describes your patient? ☐ patient is not a candidate for surgery ☐ surgery has not been curative for this patient ☐ 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 disease?	☐ Yes ☐ No
	Endogenous Cushing's Syndrome		
☐	Additional Questions:	Which of these best describes your patient? ☐ Patient is not a candidate for surgery ☐ 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?	☐ 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: (*Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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