aetna®

MEDICARE FORM

Signifor LAR (pasireotide) Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form

Note: Signifor LAR is non-preferred for acromegaly. The preferred products are Sandostatin LAR and Somatuline Depot.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Signifor LAR (pasireotide)** **Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Note: Signifor LAR is non-preferred for acromegaly. The preferred products are Sandostatin LAR and Somatuline Depot.

☐ Yes ☐ No Has the patient had prior therapy with Signifor LAR within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Sandostatin LAR (octreotide acetate) ☐ Somatuline Depot (lanreotide)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)
☐ Sandostatin LAR (octreotide acetate) ☐ Somatuline Depot (lanreotide)

_____

_____

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Acromegaly**

Please indicate the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compared to the laboratory's reference normal range based on age and/or gender: ☐ IGF-1 level is higher than the laboratory's normal range ☐ IGF-1 level is lower than the laboratory's normal range ☐ IGF-1 level falls within the laboratory's normal range

☐ Yes ☐ No Has the patient had an inadequate or partial response to surgery?

→ ☐ Yes ☐ No Is there a clinical reason why the patient has not had surgery?

☐ **Cushing's syndrome/disease**

☐ Yes ☐ No Did the patient have surgery that was not curative?

→ ☐ Yes ☐ No Is the patient a candidate for surgery?

For Continuation Requests (clinical documentation required for all requests):

☐ **Acromegaly only:**

Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy:

☐ IGF-1 level has increased ☐ IGF-1 level has decreased or normalized ☐ IGF-1 level has not changed

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.