MEDICARE FORM
Signifor LAR (pasireotide) Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Signifor LAR is non-preferred. The preferred product is Somatuline Depot.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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. The preferred product is 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 of Somatuline Depot (lanreotide)?
→ When was the member's trial and failure of Somatuline Depot? _____
→ Please describe the nature of the failure of Somatuline Depot _____
☐ Yes ☐ No Has the patient had an adverse reaction to Somatuline Depot (lanreotide)?
→ When was the member's adverse reaction to Somatuline Depot? _____
→ Please describe the nature of the adverse reaction to Somatuline Depot _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Somatuline Depot (lanreotide) when indicated for the patient's diagnosis.

_____

_____

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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? If 'Yes', chart notes indicating an inadequate or partial response to surgery must be submitted upon request.

→ ☐ Yes ☐ No Is there a clinical reason why the patient has not had surgery? If 'Yes', chart notes indicating a clinical reason for not having surgery must be submitted upon request.

☐ **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

☐ **Cushing's syndrome/disease**

☐ Yes ☐ No Is the patient receiving benefit from Signifor LAR therapy, defined as improvement in signs and symptoms of the disease or lower cortisol levels since the start of the therapy per one of the following tests: urinary free cortisol (UFC), late-night salivary cortisol, 1 mg overnight dexamethasone suppression test (DST), or longer, lower dose DST (2 mg per day for 48 hours)? If 'Yes', laboratory report indicating current cortisol level has decreased from baseline as measured by one of the following tests: (urinary free cortisol (UFC), late-night salivary cortisol, 1 mg overnight dexamethasone suppression test (DST), or longer, low dose DST (2mg per day for 48 hours) must be submitted upon request.

☐ **Carcinoid syndrome**

☐ Yes ☐ No Is the patient receiving benefit, defined as improvement or stabilization on clinical signs and symptoms since initiation of therapy?

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.