

OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Drug Requested: Signifor® (pasireotide) SQ (J-Codes: C9399/J3490 – 0.9 mg/ml SOLN)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: Check ALL boxes that apply. Authorization process will be delayed if incomplete.

For Initiation of Therapy (3 month approval). Labs and chart notes MUST be provided.

- Patient is 18 years of age or older
- Provider is an endocrinologist or neurosurgeon
- Patient has diagnosis of Cushing's disease and pituitary surgery is not an option or has not been curative (*chart notes must be submitted to document diagnosis and surgical history or contraindication to surgery*)
- Patient's baseline 24-hour urinary free cortisol level is greater than 1.5 times the upper limit of normal (*labs must be submitted for documentation*)
- Current baseline labs are attached documenting all of the following: liver function tests, fasting plasma glucose, hemoglobin A1c, thyroid function, baseline ECG, and gallbladder ultrasound

For Continued Approval of Therapy (12 month approval). Labs and chart notes MUST be provided.

- Patient's current 24-hour urinary free cortisol level is below the upper limit of normal mean (*labs must be submitted for documentation*)
- Current labs documenting patient's liver function, fasting plasma glucose and hemoglobin A_{1c} are attached
- Improvements in blood pressure, triglycerides, low-density lipoprotein cholesterol, weight and health related quality of life have been maintained while on Signifor therapy (*Chart notes must be submitted for documentation*)

Medication is being provided by a Specialty Pharmacy: PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 8/4/2017 8/31/2017.