OPTIMA HEALTH PLAN

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 1-800-750-9692. 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, if applicable*:** _____

CLINICAL CRITERIA: Check ALL boxes that apply. Authorization process will be delayed if NOT checked.

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*:** ❑ **Briova Specialty**

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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 4/20/2017
REVISED/UPDATED: ~~5/17/2017~~; ~~6/28/2017~~; ~~9/16/2017~~; **10/7/2017**;