Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Signifor® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Cushing's disease

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Submission of chart notes documenting diagnosis is required

Clinical Information:

Is the requested medication being prescribed by an endocrinologist or neurosurgeon? ❑ **Yes** ❑ **No**

Select the condition that applies to the patient from the following:

- ❑ Pituitary surgery not an option
  Submission of chart notes documenting contraindication to surgery is required
- ❑ Pituitary surgery has not been curative
  Submission of chart notes documenting surgical history is required

Is the patient's baseline 24-hour urinary free cortisol level greater than 1.5 times the upper limit of normal? ❑ **Yes** ❑ **No**
Submission of labs is required

Does the patient have current baseline labs documenting all of the following: Liver function tests, fasting plasma glucose, hemoglobin A1C, thyroid function, baseline ECG, and gallbladder ultrasound? ❑ **Yes** ❑ **No**
Submission of current baseline labs is required

Reauthorization:

Is the patient's current baseline 24-hour urinary free cortisol level below the upper limit of normal? ❑ **Yes** ❑ **No**
Submission of labs is required

Does the patient have current labs documenting all of the following: Liver function, fasting plasma glucose, and hemoglobin A1C? ❑ **Yes** ❑ **No**
Submission of current labs is required

Does the patient have chart notes documenting an improvement in all of the following: Blood pressure, triglycerides, low-density lipoprotein cholesterol, and weight and health related quality of life have been maintained while on Signifor therapy? ❑ **Yes** ❑ **No**
Submission of chart notes is required

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Signifor® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.