Prescriber Criteria Form Signifor 2024 PA Fax 970-A v1 010124.docx Signifor (pasireotide) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Signifor (pasireotide).

Drug Name: Signifor (pasireotide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Cushing's disease? [If no, then no further questions.]	Yes	No
2	Is the patient a candidate for pituitary surgery? [If no, then skip to question 4.]	Yes	No
3	Did the patient undergo pituitary surgery that was not curative? [If no, then no further questions.]	Yes	No
4	Is the requested drug being prescribed by or in consultation with an endocrinologist?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____