

**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Medicare Part D Signifor  
(pasireotide)**

**Phone: 800-728-7947 Fax back to: 866-880-4532**

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

|                           |  |
|---------------------------|--|
| <b>Patient Name:</b>      | <b>Prescriber Name:</b>                  |
| Member/Subscriber Number: | <b>Supervising Physician:</b>            |
| Date of Birth:            | Fax: Phone:                              |
| Group Number:             | Office Contact:                          |
| Address:                  | NPI: State Lic ID:                       |
| City, State ZIP:          | Address:                                 |
| Primary Phone:            | City, State ZIP:                         |
|                           | Specialty/facility name (if applicable): |

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

|   |
|---|
| Q1. What diagnosis is Signifor being prescribed for?<br><input type="checkbox"/> Cushing's disease <input type="checkbox"/> Other                           |
| Q2. Please provide the ICD code from the diagnosis provided.  |
| Q3. If diagnosis is Cushing's disease, is patient a candidate for pituitary surgery?<br><input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Q4. If diagnosis is Cushing's syndrome and patient had pituitary surgery, was surgery curative?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Q5. Is the prescriber an Endocrinologist?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Q6. Additional Comments:  |

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| <b>Patient Name:</b> | <b>Prescriber Name:</b><br><b>Supervising Physician:</b> |
|----------------------|--|

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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