PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Signifor LAR (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.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	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 LAR being prescribed for? ☐ Acromegaly ☐ Other
Q2. Please provide the ICD code from the diagnosis provided.
Q3. If diagnosis is acromegaly, is patient a candidate for surgery? ☐ Yes ☐ No
Q4. If diagnosis is acromegaly and patient has had surgery, was there an adequate response to surgery? ☐ Yes ☐ No
Q5. Is the prescriber an Endocrinologist? ☐ Yes ☐ No
Q6. Additional Comments:

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

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