JOHNS HOPKINS
HEALTH PLANS

Signifor LAR

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Signifor LAR SGM 2096-A – 08/2023.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?

❒ Acromegaly (*If checked, go to 2*)

❒ Cushing's disease (*If checked, go to 7*)

❒ Other, please specify. _____ (*If checked, no further questions*)

2. Is the patient currently on therapy with the requested medication?

❒ Yes, *Continue to 6*

❒ No, *Continue to 3*

3. How does the patient's pretreatment IGF-1 (insulin-like growth factor 1) level compare to the laboratory's reference normal range based on age and/or gender? ***ACTION REQUIRED***: Attach a laboratory report or chart note(s) with pretreatment IGF-level and reference normal range.

❒ IGF-1 level is higher than the laboratory's normal range ***ACTION REQUIRED***: Submit supporting documentation (*If checked, go to 4*)

❒ IGF-1 level is lower than the laboratory's normal range ***ACTION REQUIRED***: Submit supporting documentation (*If checked, go to 4*)

❒ IGF-1 level falls within the laboratory's normal range ***ACTION REQUIRED***: Submit supporting documentation (*If checked*, *go to 4*)

4. Has the patient had an inadequate or partial response to surgery? ***ACTION REQUIRED***: If yes, attach supporting chart note(s) indicating an inadequate or partial response to surgery.

❒ Yes, *No Further Questions*

❒ No, *Continue to 5*

5. Is there a clinical reason why the patient has not had surgery? ***ACTION REQUIRED***: If yes, attach supporting chart note(s) indicating a clinical reason for not having surgery.

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

6. How has the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy? ***ACTION REQUIRED***: If decreased or normalized, attach laboratory report indicating normal current IGF-1 levels or chart notes indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.

❒ Increased (*If checked*, *no further questions*)

❒ Decreased or normalized ***ACTION REQUIRED***: Submit supporting documentation (*If checked*, *no further questions*)

❒ No change (If checked, *no further questions*)

7. Is the patient currently receiving treatment with the requested medication?

❒ Yes, *Continue to 11*

❒ No, *Continue to 8*

8. Does the patient have a pretreatment cortisol level as indicated by one of the following tests: i.) Urinary free cortisol (UFC) level, ii.) Late-night salivary cortisol, iii.) 1 mg overnight dexamethasone suppression test (DST), iv.) Longer, low dose DST (2mg per day for 48 hours)? ***ACTION REQUIRED***: If yes, attach pretreatment cortisol level as measured by one of the following tests: urinary free cortisol (UFC) level; late-night salivary cortisol; 1mg overnight dexamethasone suppression test (DST); longer, low dose DST (2mg per day for 48 hours).

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (*If checked, go to 9*)

❒ No (*If checked, go to 9*)

❒ Unknown (*If checked, go to 9*)

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9. Did the patient have surgery that was not curative? ***ACTION REQUIRED***: If yes, attach supporting chart note(s) indicating that the patient's surgery was not curative.
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. Is the patient a candidate for surgery? ***ACTION REQUIRED***: If no, attach supporting chart note(s) indicating that surgery is not an option for the patient.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Has the patient experienced a reduction in cortisol level since the start of therapy with the requested medication as indicated by one of the following tests: i.) Urinary free cortisol (UFC), ii.) Late-night salivary cortisol, iii.) 1 mg overnight dexamethasone suppression test (DST), iv.) Longer, low dose DST (2mg per day for 48 hours)? ***ACTION REQUIRED***: If yes, laboratory report indicating current cortisol level has decreased from baseline as measured by one of the following tests: urinary free cortisol (UFC) level; late-night salivary cortisol; 1mg overnight dexamethasone suppression test (DST); longer, low dose DST (2mg per day for 48 hours) (if applicable).

❒ Yes, ***ACTION REQUIRED***: Submit supporting documentation (*If checked, no further questions*)

❒ No (*If checked, go to 12*)
❒ Unknown (*If checked, go to 12*)

12. Has the patient had an improvement of signs and symptoms of the disease since the start of therapy with the requested medication?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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