Signifor

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

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

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Criteria Questions:

1. ***Indicate where the drug is being dispensed:***
   ❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
   ❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
   ❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
   ❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
   ❑ Psychiatric Facility ❑ Pharmacy ❑ Other

2. ***Indicate where the drug is being administered:***
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office
   ❑ Outpatient Hospital ❑ Pharmacy

3. What is the diagnosis?
   ❑ Cushing's syndrome/disease ❑ Other _____

4. What is the ICD-10 code? _____

5. Is Signifor prescribed by or in consultation with an endocrinologist? ❑ Yes ❑ No

6. Is the patient currently receiving Signifor therapy? ❑ Yes ❑ No *If No, skip to #10*

7. Was Signifor therapy previously authorized by HMSA/CVS for this member? *If No, skip to #10* ❑ Yes ❑ No

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

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8. Has the patient experienced a reduction in cortisol level since the start of therapy with Signifor as indicated by one of the following tests: a) Urinary free cortisol (UFC), b) Late-night salivary cortisol, c) 1mg overnight dexamethasone suppression test (DST), or d) Longer, low dose DST (2mg per day for 48 hours?
Action Required: If 'yes', attach documentation of current cortisol level. *If Yes, no further questions*
❑ Yes ❑ No

9. Has the patient had an improvement in signs or symptoms of the disease since the start of therapy with Signifor?
Action Required: If 'yes', attach documentation of current cortisol level. ❑ Yes ❑ No *No further questions*

10. Does the patient have a pretreatment cortisol level as measured by one of the following tests: a) Urinary free cortisol (UFC), b) Late-night salivary cortisol, c) 1mg overnight dexamethasone suppression test (DST), or d) Longer, low dose DST (2mg per day for 48 hours)? ***Action Required: If 'yes', attach documentation of pretreatment cortisol level.*** ❑ Yes ❑ No

11. Did the patient have surgery that was not curative? ***Action Required: If 'yes', attach documentation of pretreatment urinary free cortisol level***. *If Yes, no further questions* ❑ Yes ❑ No

12. Is the patient a candidate for surgery? ***Action Required: If 'no', attach documentation of pretreatment urinary free cortisol level***. ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

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

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