| Prescriber Criteria Form<br><br>Signifor 2025 PA Fax 970-A v1 010125.docx<br>Signifor (pasireotide)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>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:<br>Signifor (pasireotide) |
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| **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?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 2 | Is the patient a candidate for pituitary surgery?<br>[If no, then skip to question 4.] | Yes ◯ | No ◯ |
| 3 | Did the patient undergo pituitary surgery that was not curative?<br>[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. |
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| **Prescriber (or Authorized) Signature:** _____ **Date:**_____ |