Signifor LAR

CareFirst 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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____
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*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Signifor LAR SGM 2096-A – 04/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?

❒ Acromegaly, *Continue to 2*

❒ Cushing's disease, *Continue to 7*

❒ Other, please specify. _____, *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 laboratory report indicating high pretreatment insulin-like growth factor-1 (IGF-1) level.
❒ IGF-1 level is higher than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ IGF-1 level is lower than the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ IGF-1 level falls within the laboratory's normal range ***ACTION REQUIRED****: Submit supporting documentation, Continue 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 note(s) indicating that the patient's IGF-1 level has decreased or normalized since initiation of therapy.

❒ Increased, *No further questions*

❒ Decreased or normalized ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No change, *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 (2 mg 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; 1 mg overnight dexamethasone suppression test (DST); longer, low dose DST (2 mg per day for 48 hours).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ No, *Continue to 9*

❒ Unknown, *Continue to 9*

9. Did the patient have surgery that was not curative?

❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. Is the patient a candidate for surgery?
❒ 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 (2 mg 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; 1 mg overnight dexamethasone suppression test (DST); longer, low dose DST (2 mg per day for 48 hours) (if applicable).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *Continue to 12*

❒ Unknown, *Continue 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 CVS Caremark or the benefit plan sponsor.

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

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