Health Alliance™

Pharmacy Drug Policy Checklist

POLICY NAME	Signifor and Signifor LAR (pasireotide)	POLICY #	2421P

Criteria

Criteria for Initial Coverage of Signifor for the Treatment of Cushing's Syndrome

- ☐ Diagnosis of Cushing's syndrome/disease
- ☐ Documentation that the member underwent a surgical procedure which was not curative or that the member is not a candidate for surgery
- ☐ Signifor is prescribed by or in consultation with an endocrinologist (hormone doctor)
- ☐ Submission of baseline fasting plasma glucose and/or HbA1c levels which show controlled glucose levels, OR
  - Signifor may increase blood sugar levels
- ☐ Documentation which shows the member's glucose levels are not controlled while on maximum antidiabetic therapy
  - Signifor may increase blood sugar levels

Criteria for Continued coverage of Signifor for the Treatment of Cushing's Syndrome

- ☐ Documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels,
- ☐ Documentation of continued controlled blood glucose levels, OR
- ☐ Documentation that the member's glucose levels are not controlled while on maximum antidiabetic therapy.

Criteria for coverage of Signifor LAR for the Treatment of Acromegaly

- ☐ Prescribed by an endocrinologist (hormone doctor)
- ☐ Diagnosis of acromegaly
- ☐ Documented high growth factor hormone (IGF-1) for age
- ☐ Lab-specific values
- ☐ Documented inadequate response to surgery or radiotherapy or clinical reason why the patient has not had surgery or radiotherapy

- [ ] Documented failure of or contraindication to Sandostatin or Sandostatin LAR