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

- ☐ **1.1** Diagnosis of Cushing's syndrome/disease
- ☐ **1.2** Documentation that the member underwent a surgical procedure which was not curative or that the member is not a candidate for surgery
- ☐ **1.3** Signifor is prescribed by or in consultation with an endocrinologist (hormone doctor)
- ☐ **1.4** Submission of baseline fasting plasma glucose and/or HbA1c levels which show controlled glucose levels, OR
  - Signifor may increase blood sugar levels
- ☐ **1.5** 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

- ☐ **2.1** Documentation of a clinically meaningful reduction in 24-hour urinary free cortisol (UFC) levels,
- ☐ **2.2** Documentation of continued controlled blood glucose levels, OR
- ☐ **2.3** 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

- ☐ **3.1** Prescribed by an endocrinologist (hormone doctor)
- ☐ **3.2** Diagnosis of acromegaly
- ☐ **3.3** Documented high growth factor hormone (IGF-1) for age
- ☐ **3.4** Lab-specific values
- ☐ **3.5** Documented inadequate response to surgery or radiotherapy or clinical reason why the patient has not had surgery or radiotherapy
- ☐ **3.6** Documented failure of or contraindication to Sandostatin or Sandostatin LAR