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| --- | --- | --- | --- |
| **Criteria Title** | Somatostatin Analogue | | |
| **Criteria Subtitle** | Signifor (pasireotide), Signifor LAR (pasireotide) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SIGNIFOR | 070367 | GCNSeqNo |
| SIGNIFOR | 070368 | GCNSeqNo |
| SIGNIFOR | 070369 | GCNSeqNo |
| SIGNIFOR LAR | 073222 | GCNSeqNo |
| SIGNIFOR LAR | 073223 | GCNSeqNo |
| SIGNIFOR LAR | 073224 | GCNSeqNo |
| SIGNIFOR LAR | 078783 | GCNSeqNo |
| SIGNIFOR LAR | 078784 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | Which medication is being requested? | Signifor (pasireotide) | 1000 |
| Signifor LAR (pasireotide) | 3000 |
| 2 | 1000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1001 |
| Continuation (re-authorization request) | 2000 |
| 3 | 1001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select and Free Text | Has the provider submitted documentation of the patient’s baseline fasting plasma glucose, hemoglobin A1c, liver function tests, electrocardiogram, gall bladder ultrasound, and electrolyte levels prior to initiation of therapy?  If yes, please provide documentation. | Y | 1003 |
| N | 1235 |
| 5 | 1003 |  | Select and Free Text | Does the patient have a contraindication to therapy with ketoconazole, cabergoline, metyrapone, or octreotide?  If yes, please submit the medication name and reason for inability to use. | Y | END (Pending Manual Review) |
| N | 1004 |
| 6 | 1004 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days of therapy with ketoconazole, cabergoline, metyrapone, or octreotide within the past 60 days?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 2000 |  | Select and Free Text | Has the provider submitted documentation of a cortisol level checked 60 days after initiation of therapy?  If yes, please provide documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 3000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request | 3001 |
| Continuation (re-authorization request) | 4000 |
| 9 | 3001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 3002 |
| N | 1235 |
| 10 | 3002 |  | Select and Free Text | Has the provider submitted documentation of the patient’s baseline fasting plasma glucose, hemoglobin A1c, liver function tests, electrocardiogram, gall bladder ultrasound, and electrolyte levels prior to initiation of therapy?  If yes, please provide documentation. | Y | 3003 |
| N | 1235 |
| 11 | 3003 |  | Select and Free Text | Has the provider submitted clinical rationale for prescribing Signifor LAR instead of Signifor?  If yes, please provide documentation. | Y | 3004 |
| N | 1235 |
| 12 | 3004 |  | Select | Has the patient had inadequate clinical response to surgery or surgery is not an option? | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 4000 |  | Select and Free Text | Has the provider submitted documentation of clinical response?  If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:

Signifor-Initial authorizations:60 days, subsequent authorizations: 365 days.

Signifor LAR- 365 days.

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| **Last Approved** | 4/10/2023 |
| **Other** |  |