BlueCross BlueShield
Federal Employee Program

SIGNIFOR LAR
MEDICAL BENEFIT ONLY
PRESCRIBER
PRIOR AUTHORIZATION FORM

Fax completed form to:
1 (844) 652-8285

Patient Information (required)			Provider Information (required)		
Date:			Provider Name and Office Contact:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ☐ Male ☐ Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
HCPCS code:			ICD-10:		
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

SIGNIFOR LAR (pasireotide pamoate)

****NOTE:** Form must be completed in its **entirety** for processing, **please check ALL boxes that apply.****

☐ This is **INITIATION** of therapy

☐ Patient is 18 years of age or older

Patient's diagnosis is:

☐ Acromegaly

☐ Surgery was not curative, or patient is NOT a candidate for surgery
☐ Patient had an inadequate treatment response, intolerance, or contraindication to octreotide or lanreotide

☐ Cushing's disease

☐ Pituitary surgery was not curative, or patient is NOT a candidate for surgery

☐ Other diagnosis (please provide clinical documentation supporting medical necessity)

☐ This is a PA renewal for **CONTINUATION** of therapy (patient has been on the requested medication within the past **6 months**, excluding samples)

☐ Patient is 18 years of age or older

Patient's diagnosis is:

☐ Acromegaly

☐ Cushing's disease

☐ Other diagnosis (please provide clinical documentation to support ongoing medical necessity)

PLEASE NOTE: Signifor LAR may be considered investigational in patients less than 18 years of age and for all other indications.