UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1093-9
Program	Prior Authorization/Notification
Medication	Signifor® (pasireotide diaspartate)
P&T Approval Date	2/2013, 5/2013, 11/2013, 11/2014, 11/2015, 9/2016, 9/2017, 9/2018, 9/2019, 9/2020, 9/2021
Effective Date	12/1/2021; Oxford only: 12/1/2021

1. Background:

Signifor (pasireotide diaspartate) is a somatostatin analog indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

2. Coverage Criteria:

A. Initial Authorization

1. Signifor will be approved based on **both** of the following criteria:

a. Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

-AND-

b. **One** of the following:

(1) Pituitary surgery has not been curative for the patient
(2) Patient is not a candidate for pituitary surgery

Authorization will be issued for 6 months.

B. Reauthorization

1. Signifor will be approved based on the following criterion:

a. Documentation of positive clinical response to Signifor therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Signifor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2020.

Program	Prior Authorization/Notification - Signifor (pasireotide diaspartate) Notification
Change Control	
2/2013	New program.
5/2013	Initial authorization period revised based upon consultant feedback.
11/2013	Formatting update. Removal of dose information in Background Section.
11/2014	Annual review with no change to coverage.
11/2015	Annual review. Updated background info. Changed authorization period from 3 months to 6 months. Updated references.
9/2016	Annual review. No change to coverage criteria.
9/2017	Annual review with no changes to coverage criteria.
9/2018	Annual review with no changes to coverage criteria. Updated reference.
9/2019	Annual review with no changes to coverage criteria. Updated reference.
9/2020	Annual review with no changes to coverage criteria. Updated reference.
9/2021	Annual review with no changes to coverage criteria. Updated reference.