

SIGNIFOR

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION

| | | |
|--------------------|-------------|------------|
| Today's Date: | First Name: | Last Name: |
| Member ID #: | Address: | |
| City: | State: | Zip: |
| Phone: | DOB: | Allergies: |
| Primary Insurance: | Policy #: | Group #: |

Is the requested medication **NEW** or a **CONTINUATION of THERAPY** ? If so, start date: _____
 Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

| | | | |
|-------------|------------|-----------|------------|
| First Name: | Last Name: | M.D./D.O. | |
| Address: | City: | State: | Zip: |
| Phone: | Fax: | NPI #: | Specialty: |

Office Contact Name / Fax Attention to:

Medication: _____ **Strength:** _____

Directions for use: _____

Diagnosis (Please be specific & provide as much information as possible): _____ **ICD 10 Code:** _____

SECTION C – CLINICAL INFORMATION

Initial Requests:
 Does this patient have a diagnosis of endogenous Cushing's disease? (*Circle Response*)
YES or NO

Did this patient undergo pituitary surgery that was not curative for the patient? (*Circle Response*)
YES or NO

Is this patient a candidate for pituitary surgery? (*Circle Response*) **YES or NO**

Is the prescriber an endocrinologist? (*Circle Response*) **YES or NO**

Re-Authorization Requests:

Has this patient demonstrated a positive clinical response to Signifor therapy? (*Circle Response*)
YES or NO

Please describe benefit of therapy: _____

Physician Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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