Reference number(s)
2124-A

SPECIALTY GUIDELINE MANAGEMENT

SIGNIFOR (pasireotide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Signifor is indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

Cushing's syndrome/disease
Authorization of 12 months may be granted for the treatment of Cushing's disease/syndrome in members who either have had surgery that was not curative OR for members who are not a candidates for surgery.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for 12 months for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Signifor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2018.
2. Nieman LK, Biller B, Findling JW, et al. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2015;100:2807-2831.