Prescription & Enrollment Form

Signifor® & Signifor® LAR (pasireotide)—for injection

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____

Insured's name _____

Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

Indication: ❑ Cushing's Disease ❑ Acromegaly ❑ Other _____

Clinical impression _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

Please attach baseline/most recent laboratory and biomarker values, prior dates of surgery, and past medication therapies used with referral.

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Signifor® (pasireotide) injection, for **subcutaneous use**	❑ 0.3 mg ampules ❑ 0.6 mg ampules ❑ 0.9 mg ampules (60 ampules per box)	❑ Inject the contents of one ampule subcutaneously twice daily ❑ Other: _____	❑ 1-month supply ❑ 3-month supply ❑ Other: _____ Refills _____
❑ Signifor® LAR (pasireotide) for injectable suspension, for **intramuscular use**	❑ 10 mg kit ❑ 20 mg kit ❑ 30 mg kit ❑ 40 mg kit ❑ 60 mg kit	❑ Healthcare provider to inject one syringe intramuscularly every 28 days ❑ Other: _____	❑ 1-month supply ❑ Other: _____ Refills _____

Supplies: (supplies will be sent unless indicated below) Dispense needles, syringes, ancillary supplies, and home medical equipment necessary to administer medication.

Quantity to be supplied sufficient for prescribed days supply above.

Signifor administration supplies include:

- 1 mL syringe
- 27G 1/2" needle
- 18G 1/2" filter needle
- Alcohol prep pads
- Band-Aid® bandages
- Sharps container

Signifor LAR administration supplies include:

- Alcohol swabs
- Sharps container

Note: Signifor LAR kit includes diluent, syringe, and injection needle supplied by manufacturer

❑ No supplies

Does Signifor LAR patient require or prefer home administration?

❑ Yes: Skilled nursing visit as needed to administer medication and assess general status and response to therapy

❑ No: Patient to receive injection from designated clinic/infusion provider

EXPECTED DATE OF NEXT INJECTION _____ Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

Home health agency to administer? ❑ No ❑ Yes Agency name & contact _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the team at 888.454.8488. To reach your team, call toll-free 888.454.8860.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.