GEORGIA MEDICAID FEE-FOR-SERVICE
SIGNIFOR PA SUMMARY

Preferred	Non-Preferred
N/A	Signifor (pasireotide)

LENGTH OF AUTHORIZATION: 1 Year

NOTE: The criteria details below are for the outpatient pharmacy program. If a medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at www.mmis.georgia.gov.

PA CRITERIA:

- ❖ Approvable for members 18 years of age or older with Cushing's disease (syndrome) for whom pituitary surgery is not an option or has not been curative.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.