CIGNA
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

# CIGNA HealthCare Prior Authorization Form
# -Antifungal Therapy-

**Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.**

| PROVIDER INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Provider Name: | | | **Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed** | | |
| Specialty: | * DEA or TIN: | | | | |
| Office Contact Person: | | | * Patient Name: | | |
| Office Phone: | | | * CIGNA ID: | | |
| Office Fax: | | | * Date Of Birth: | | |
| * Is your fax machine kept in a secure location? Yes ☐ No ☐<br>* May we fax our response to your office? Yes ☐ No ☐ | | | * Patient Street Address: | | |
| Office Street Address: | | | City | State | Zip |
| City | State | Zip | Patient Phone: | | |

**Medication requested:**

☐ Penlac (ciclopirox) ☐ CNL 8 (ciclopirox lacquer remover)

Strength & Dose: Duration of therapy:

**Diagnosis related to use (please specify):**

☐ Onychomycosis ☐ Superficial fungal infection (*please provide diagnosis code*): _____ ☐ Other (*please specify*): _____

Diagnosis is related to: ☐ Toenail ☐ Fingernail ☐ Other (*please specify*):

**Formulary alternatives tried:**

Has oral onychomycosis therapy been used as treatment within the past 32 weeks? ☐ Yes ☐ No

Penlac requests only - Was there failure, contraindication or intolerance to oral terbinafine (Lamisil) tablets? ☐ Yes ☐ No

Please list any other medications that the patient has tried for their given diagnosis:

**Adverse Reaction Risks:**

For the diagnosis of onychomycosis, a positive KOH stain, positive PAS stain or positive fungal culture is required.
Which test was done, and what was the date?

☐ Positive KOH (date of test: _____ ) ☐ Positive PAS (date of test: _____ )
☐ Positive fungal culture (date of test: _____ ) ☐ no test was done

Please check all that apply to this patient:
☐ Patient is experiencing pain which limits normal activity
☐ Patient has a significant vascular compromise
☐ Patient is diabetic
☐ Patient is immunocompromised due to disease, transplant or medical intervention (such as AIDS treatment, anti-rejection treatment for bone marrow or solid organ transplant, or chemotherapy for cancer)

**CIGNA HealthCare's coverage position on this and other medications may be viewed online at:**
**http://www.cigna.com/customer_care/healthcare_professional/coverage_positions**

**Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.**

*Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.*

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