Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Avycaz
(avibactam sodium; ceftazidime)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician 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, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
Avycaz: ☐ Is this a new start? ☐ Yes ☐ No Start date:

Dose: Frequency of therapy: Duration of therapy:
What is your patient's current weight? ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is your patient a candidate for home infusion? ☐ Yes ☐ No
Does the physician have an in-office infusion site? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
Is your patient being treated for either of the following?
☐ complicated intra-abdominal infection
☐ complicated urinary tract infection, including pyelonephritis
☐ neither of the above

(if neither) What is the diagnosis related to use?

(if intra-abdominal) Is the infection caused by any of the following: Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis, Providencia stuartii, Enterobacter cloacae, Klebsiella oxytoca, or Pseudomonas aeruginosa? ☐ Yes ☐ No
(if intra-abdominal) Will Avycaz be used in combintation with metronidazole? ☐ Yes ☐ No
(if urinary) Is the infection caused by any of the following: Escherichia coli, Klebsiella pneumoniae, Citrobacter koseri, Enterobacter aerogenes, Enterobacter cloacae, Citrobacter freundii, Proteus species, or Pseudomonas aeruginosa? ☐ Yes ☐ No

(if no) Please provide clinical support for the use of this drug in your patient (including any lab results).

Additional Information: *(including labs)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005