Cigna®

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

Beovu, Byooviz, Eylea, Lucentis, Vabysmo

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:
☐ Beovu ☐ Byooviz ☐ Eylea syringe ☐ Eylea vial
☐ Lucentis 0.3mg/0.05ml syringe ☐ Lucentis 0.3mg/0.05ml vial ☐ Lucentis 0.5mg/0.05ml syringe
☐ Lucentis 0.5mg/0.05ml vial ☐ Vabysmo 6mg (0.05mL of 120mg/mL) vial
☐ Other:

Dose: Frequency of therapy: Duration of therapy:

ICD10:

Will the patient ALSO be using any of the following in the same eye during treatment with the requested medication? (check all that apply):
☐ Avastin ☐ Beovu ☐ Byooviz ☐ Eylea ☐ Lucentis ☐ Macugen ☐ Vabysmo
☐ none of these

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

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

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

Diagnosis related to use:
☐ Best disease
☐ Coats' disease
☐ Central serous chorioretinopathy
☐ diabetic macular edema (DME) only
☐ diabetic retinopathy (DR) only
☐ diabetic macular edema (DME) AND diabetic retinopathy (DR)
☐ macular edema following retinal vein occlusion (RVO)
☐ myopic choroidal neovascularization (mCNV)
☐ ocular histoplasmosis syndrome
☐ other neovascular diseases of the eye (for example, neovascular glaucoma, retinopathy of prematurity, sickle cell neovascularization, choroidal neovascular conditions)
☐ neovascular (wet) age-related macular degeneration (AMD)
☐ radiation maculopathy
☐ refractory noninfectious uveitic cystoid macular edema

☐ Other *(please specify)*:

Clinical Information:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy

(if continued therapy) Has your patient had beneficial clinical response to the requested drug? ☐ Yes ☐ No

(if DME and Eylea) Was your patient's baseline visual acuity worse than 20/40 (before starting any therapy for this disease)? ☐ Yes ☐ No

(if no) Does your patient have significant retinal thickening? ☐ Yes ☐ No

Is this patient currently already receiving the requested medication? Note: Receipt of sample product does NOT satisfy any criteria requirements for coverage. ☐ Yes ☐ No

(if no and Beovu, Byooviz, Eylea, Lucentis or Vabysmo) The covered alternative is generic repackaged bevacizumab. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

_____

(if not already on the requested medication and Beovu, Byooviz, Eylea, Lucentis or Vabysmo) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet (safety is not a concern of the prescriber).
☐ The patient tried the alternative, but has a significant intolerance to it.
☐ The patient cannot try the alternative because of a contraindication to it.
☐ The patient cannot try the alternative because the safety of using it (or the supplier of it) is of significant concern.
☐ other

Additional Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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