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

Durysta
(bimatoprost ophthalmic implant)

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: ☐ Durysta 10mcg implant ICD10:

Directions for use: Quantity:

Has your patient previously been treated with the requested drug? ☐ Yes ☐ No
(if previously treated) Which eye(s) was the implant inserted? ☐ Right eye ☐ Left eye ☐ Both eyes

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:
☐ reduction of intraocular pressure (IOP) due to open-angle glaucoma
☐ reduction of intraocular pressure (IOP) due to ocular hypertension
☐ Other (Please specify):

Clinical Information:
Is the requested drug being prescribed by, or in consultation with, an ophthalmologist? Yes ☐ No ☐

What other alternatives have been tried? Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

Has the patient tried and had an inadequate response to at least TWO ophthalmic prostaglandins either as monotherapy or as concomitant therapy (examples of ophthalmic prostaglandins include, bimatoprost, latanoprost, latanoprostene bunod, tafluprost, travoprost)? Yes ☐ No ☐

(if no) Does the patient have a contraindication per FDA label, significant intolerance, or is not a candidate* for ophthalmic prostaglandins? *Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], or other attributes/conditions or is unable to administer and requires this dosage formulation Yes ☐ No ☐

Has the patient tried and had an inadequate response to at least TWO ophthalmic products (either as monotherapy or as concomitant therapy) from TWO different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension including the following:

a. Alpha-agonists (for example, brimonidine)
b. Beta-blockers (for example, betaxolol, timolol)
c. Carbonic anhydrase inhibitors (for example, brinzolamide, dorzolamide)
d. Rho kinase inhibitors (for example, netarsudil)?

Yes ☐ No ☐

(if no) Does the patient have a contraindication per FDA label, significant intolerance, or is not a candidate* for ophthalmic alpha-agonists, beta-blockers, carbonic anhydrase inhibitors, or rho kinase inhibitors? *Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], or other attributes/conditions or is unable to administer and requires this dosage formulation Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, 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.

v091521