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

Durolane, Euflexxa, Gel-One, Gelsyn 3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, Trivisc, Visco-3

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:
☐ Durolane ☐ Euflexxa ☐ Gel-One ☐ Gelsyn 3
☐ Genvisc 850 ☐ Hyalgan ☐ Hymovis ☐ Monovisc ☐ Orthovisc
☐ Supartz FX ☐ Synojoynt ☐ Synvisc ☐ Synvisc-One ☐ Triluron
☐ Trivisc ☐ Visco-3

Please specify site of injection for this request: ☐ left knee ☐ right knee ☐ both knees
☐ Other:_____

Quantity: Duration of therapy: Jcode: ICD10:

(if Euflexxa, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Supartz FX. Synojoynt, Triluron, Trivisc or Visco-3) The drug you're requesting is given as a series of weekly injections. Has your patient already received any injections for this series? ☐ Yes ☐ No
(if yes) How many injections in this series were already received? _____

Has your patient been previously treated in this injection site with any viscosupplementation product (Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, Trivisc, Visco-3)? ☐ Yes ☐ No
(if previously treated) What is the date of the last injection your patient received in this injection site and what was the product used? _____
(if previously treated) Does your patient have a history of beneficial clinical response in this injection site as determined by comparison of documented baseline objective measurements done pre-treatment and at re-evaluation? ☐ Yes ☐ No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

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*

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:
☐ osteoarthritis of the knee ☐ Other_____

Clinical Information
Has your patient's diagnosis been documented by radiologic evidence of osteoarthritis of the knee (for example, joint space

narrowing, subchondral sclerosis, osteophytes, subchondral cysts)? ☐ Yes ☐ No

Please provide the names, dates and documented results of each therapy or medication taken to treat your patient's osteoarthritis of the knee(s). _____

Did your patient try either pharmacotherapy [acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), tramadol] OR physical therapy for at least 6 weeks?
☐ Yes, but had less than adequate results
☐ No, but these are good options for the patient to try
☐ No, because they tried it for less than 6 weeks
☐ No, because patient is not a candidate for either therapy

Did your patient try corticosteroid injections in the knee(s)?
☐ Yes, and had good results
☐ Yes, but had less than adequate results
☐ No, but this is a good option for the patient to try
☐ No, because patient is not a candidate for corticosteroid injections in the knee(s)

Does your patient have a documented intolerance or contraindication per FDA label to any of the following? (check all that apply):

☐ Durolane	☐ Euflexxa	☐ Gel-One	☐ Gelsyn 3	☐ GenVisc 850
☐ Hyalgan	☐ Hymovis	☐ Monovisc	☐ Orthovisc	☐ Supartz FX
☐ Synojoynt	☐ Synvisc	☐ Synvisc-One	☐ Triluron	☐ Trivisc
☐ Visco-3				

Additional pertinent information

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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