Eylea, Lucentis, Macugen

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

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:
☐ Eylea ☐ Lucentis ☐ Macugen

Dose: Frequency of therapy: Duration of therapy:

ICD10:

Will any of the following drugs be used in the same eye AT THE SAME TIME as the requested drug? (check all that apply):
☐ Avastin ☐ Eylea ☐ Lucentis ☐ Macugen ☐ 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*

***If you wish to order this medication from Accredo Specialty Pharmacy, please call 1-866-759-1557 for an order form.*

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:
☐ age-related macular degeneration (AMD)
☐ diabetic retinopathy (DR)
☐ macular edema (ME)
☐ myopic choroidal neovascularization (mCNV)
☐ ocular histoplasmosis syndrome
☐ retinal vein occlusion (RVO [BRVO, CRVO])
☐ retinopathy of prematurity
☐ Other *(please specify)*:

Clinical Information:
(if AMD) Does your patient have the wet or neovascular type of AMD? ☐ Yes ☐ No
(if ME) Does your patient have a history of either of the following?
☐ diabetes (DME)
☐ retinal vein occlusion (RVO, BRVO, CRVO)
☐ neither of the above
(if RVO) Does your patient also have macular edema (ME)? ☐ Yes ☐ No

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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