CIGNA
Pharmacy Services

Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare
- Angiotensin Receptor Blocker (ARB) Therapy -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider 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 or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested: (*please specify name, strength, and dosing schedule)*:

Diagnosis related to use:

Clinical Information:

1. Is this request for new treatment? Yes ☐ No ☐
   If *continued therapy*: when did the patient begin treatment?

2. Did the patient have a failure, contraindication, or intolerance to ACE inhibitor therapy? Yes ☐ No ☐
   If *yes*: please specify which ACE inhibitors were tried:
   If *no*: is there a contraindication to switching to ACE inhibitors? Yes ☐ No ☐
   If *yes*, please explain contraindication:

3. Has there been a positive clinical response to ARBs or ARBs combination therapy? Yes ☐ No ☐

4. Did the patient have a failure, contraindication, or intolerance to a formulary ARB agent (i.e. Losartan (Cozaar/Hyzaar), Valsartan (Diovan/Diovan HCT))? Yes ☐ No ☐
   If *yes*, please specify which ARB agent was tried:
   If *no*: is there a contraindication to switching to a formulary ARB agent? Yes ☐ No ☐
   If *yes*, please explain contraindication:

5. Does the patient have a history of Chronic Kidney disease? Yes ☐ No ☐
6. Does the patient have a history of Diabetes? Yes ☐ No ☐

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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