



**CIGNA**

**Pharmacy Services**

Phone: (800)244-6224

Fax: (800)390-9745

# CIGNA HealthCare Prior Authorization Form -Oral Antifungal 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 <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

**Medication requested:**

Lamisil (terbinafine hcl)    Sporanox (itraconazole)    Penlac (ciclopirox)    CNL 8 (ciclopirox lacquer remover)

Strength & Dose:

Duration of therapy:

**Diagnosis related to use (please specify):**

Onychomycosis    Superficial fungal infection (*please provide diagnosis code*): \_\_\_\_\_    Other (*please specify*): \_\_\_\_\_

Diagnosis is related to:    Toenail    Fingernail    Other (*please specify*):

**Formulary alternatives tried:**

Has oral onychomycosis therapy been used as treatment within the past 32 weeks?    Yes    No

Penlac requests only - Was there failure, contraindication or intolerance to oral terbinafine (Lamisil) tablets?    Yes    No

Please list any other medications that the patient has tried for their given diagnosis:

**Adverse Reaction Risks:**

For the diagnosis of onychomycosis, a positive KOH stain, positive PAS stain or positive fungal culture is required. Which test was done, and what was the date?

Positive KOH                      (date of test: \_\_\_\_\_)                       Positive PAS                      (date of test: \_\_\_\_\_)  
 Positive fungal culture (date of test: \_\_\_\_\_)                       no test was done

Please check all that apply to this patient:

- Patient is experiencing pain which limits normal activity
- Patient has a significant vascular compromise
- Patient is diabetic
- Patient is immunocompromised due to disease, transplant or medical intervention (such as AIDS treatment, anti-rejection treatment for bone marrow or solid organ transplant, or chemotherapy for cancer)

**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](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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