



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Tamiflu, Relenza -

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:					
<input type="checkbox"/> Tamiflu 75mg capsule <input type="checkbox"/> Tamiflu 12mg/ml suspension <input type="checkbox"/> Relenza 5mg Diskhaler <input type="checkbox"/> Other (<i>please specify</i>):					
Dose and Quantity:			Duration of therapy:		
Clinical Data:					
Which is the requested medication being prescribed for?		<input type="checkbox"/> Treatment of Active Infection		<input type="checkbox"/> Prophylaxis	
Has the medication already been purchased?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>For Treatment of active illness (please complete the following question):</u>					
Was the onset of symptoms within the last 48 hours?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>For Prophylaxis of illness (please complete the remaining questions):</u>					
Was this patient immunized within the last 14 days?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is this patient at high risk for developing influenza (as identified by CDC guidelines)?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please specify risk factor(s):					
<input type="checkbox"/> Age 65 or older		<input type="checkbox"/> diabetes		<input type="checkbox"/> on immunosuppressive therapy	
<input type="checkbox"/> nursing home/chronic care facility resident		<input type="checkbox"/> on long-term aspirin therapy		<input type="checkbox"/> severe anemia	
<input type="checkbox"/> chronic heart, lung or kidney disease		<input type="checkbox"/> other (<i>please specify</i>):		<input type="checkbox"/> asthma	
Is this patient in close contact with an individual infected with influenza?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, what Type of Influenza does the contact have?		<input type="checkbox"/> Type A <input type="checkbox"/> Type B		<input type="checkbox"/> Unknown	
Was the exposure within the last 48 hours?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Has there been an outbreak of influenza in the patient's community?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, what Type of Influenza is prevalent in the community?		<input type="checkbox"/> Type A <input type="checkbox"/> Type B			

Clinical Data: (Continued)

If for Influenza Type A, does the patient have contraindication to amantadine or rimantadine therapy? Yes No

If YES, please specify the nature of the contraindication:

What is the patient's current weight?

Additional pertinent information:

**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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