



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form -Oral Onychomycosis 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 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

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

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)

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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