



**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:		
<b>Medication requested:</b> <input type="checkbox"/> LAMISIL (terbinafine hcl) <input type="checkbox"/> SPORANOX (itraconazole) <input type="checkbox"/> PENLAC (ciclopirox) <input type="checkbox"/> CNL 8 (ciclopirox lacquer remover)					
Strength & Dose:			Duration of therapy:		
<b>Diagnosis related to use (please specify):</b> <input type="checkbox"/> Onychomycosis <input type="checkbox"/> Superficial fungal infection <input type="checkbox"/> Other (please specify):					
Diagnosis is related to: <input type="checkbox"/> Toenail <input type="checkbox"/> Fingernail <input type="checkbox"/> Other (please specify):					
<b>Formulary alternatives tried:</b> Has oral onychomycosis therapy been used as treatment within the past 32 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Penlac requests only - Was there failure, contraindication or intolerance to oral terbinafine (Lamisil) tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please list any other medications that the patient has tried for their given diagnosis:					
<b>Adverse Reaction Risks:</b> 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?					
<input type="checkbox"/> Positive KOH		(date of test:                    )		<input type="checkbox"/> Positive PAS	
<input type="checkbox"/> Positive fungal culture		(date of test:                    )		<input type="checkbox"/> no test was done	
Please check all that apply to this patient:					
<input type="checkbox"/> Patient is experiencing pain which limits normal activity					
<input type="checkbox"/> Patient has a significant vascular compromise					
<input type="checkbox"/> Patient is diabetic					
<input type="checkbox"/> 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)					
<b>Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.</b>					
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 <a href="http://www.cigna.com">http://www.cigna.com</a> .					

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