



**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 <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: (please specify name, strength, and dosing schedule):					
Diagnosis related to use:					
Clinical Information:					
1. Is this request for new treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> If <i>continued therapy</i> : when did the patient begin treatment?					
2. Did the patient have a failure, contraindication, or intolerance to ACE inhibitor therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> If <i>yes</i> : please specify which ACE inhibitors were tried: If <i>no</i> : is there a contraindication to switching to ACE inhibitors? Yes <input type="checkbox"/> No <input type="checkbox"/> If <i>yes</i> , please explain contraindication:					
3. Has there been a positive clinical response to ARBs or ARBs combination therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 <input type="checkbox"/> No <input type="checkbox"/> If <i>yes</i> , please specify which ARB agent was tried: If <i>no</i> : is there a contraindication to switching to a formulary ARB agent? Yes <input type="checkbox"/> No <input type="checkbox"/> If <i>yes</i> , please explain contraindication:					
5. Does the patient have a history of Chronic Kidney disease? Yes <input type="checkbox"/> No <input type="checkbox"/>					
6. Does the patient have a history of Diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Additional pertinent information: (please include clinical reasons for drug, relevant lab values, etc.):					
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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