CIGNA®

Pharmacy Services

Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Avonex, Betaseron, Copaxone, Rebif -

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 ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

☐ AVONEX (Interferon Beta-1b)
☐ BETASERON (Interferon Beta-1b)
☐ COPAXONE (Glatiramer Acetate)
☐ REBIF (Interferon Beta-1a)

Strength & Dose: Duration of therapy: J-Code:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):

What is the patient's diagnosis related to use?

☐ Clinically Definite Multiple Sclerosis ☐ Relapsing Remitting Multiple Sclerosis
☐ Secondary Progressive Multiple Sclerosis with Relapses ☐ Other (please specify):

Is this for new treatment or a continuation of therapy?
☐ New treatment ☐ Continuation of therapy

Please list the start date of therapy:

If there has been failure, contraindication or intolerance to any prior therapies, please check all that apply:
☐ Avonex
☐ Rebif
☐ Copaxone
☐ Betaseron

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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