



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Insulin Pens -

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"/> Humalog | <input type="checkbox"/> Humulin N | <input type="checkbox"/> Humulin 70/30 | <input type="checkbox"/> Humulin 70/30 | <input type="checkbox"/> Humulin 70/30 |
| <input type="checkbox"/> Lantus | <input type="checkbox"/> Lantus Solostar | <input type="checkbox"/> Lantus Solostar | <input type="checkbox"/> Novolin N Innolet | <input type="checkbox"/> Novolin 70/30 Innolet |
| <input type="checkbox"/> Novolin N | <input type="checkbox"/> Novolin R | <input type="checkbox"/> Novolin 70/30 | <input type="checkbox"/> Novolog | <input type="checkbox"/> Levemir |
| <input type="checkbox"/> Other: (Please Specify) | | | | |

Strength, Dose, and Quantity:

Diagnosis related to use

- Diabetes
 Other (please specify):

Clinical Information:

- | | | |
|-----------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 1. Is the patient visually impaired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the patient have dexterity problems that limit the use of syringes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the patient's school or job environment preclude the use of syringes/vials? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does the patient use a Disetronic Insulin Pump (D-TRONplus)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the patient have compliance problems attributable to the use of syringes/vials? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Has the patient tried the insulin pen with stable regimen for at least 30 days? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has that resulted in improved glycemic control or improved compliance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Additional pertinent information:

**CIGNA HealthCare's coverage positions 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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