Instructions for submitting a Massachusetts Prior Authorization Form Electronically

For Medical Providers

To submit a Massachusetts prior authorization form electronically, providers must register for access to Cigna's online prior authorization tool.

To initiate registration for the tool, send an email to PMAC@Cigna.com. Include the following information with your submission:

- Provider or facility name
- Mailing address
- Email address
- Contact name
- Contact telephone number

If you prefer to submit a prior authorization form via fax, please send it to **866.873.8279**.

To contact Cigna's Coverage Review Team, please call the phone number listed on the back of the customer's ID card or 800.Cigna24 (800.244.6224).

PCOMM-2022-1531-MA

CARDIAC IMAGING PRIOR AUTHORIZATION FORM

Myocardial Perfusion Imaging (MPI); Stress Echocardiogram; Multiple Gated Acquisition Scan (MUGA); Transthoracic Echocardiogram (TTE); Transesophageal Echocardiogram (TEE)

SECTION 1. MEMBER DEMOGRAPHICS

Patient Name (First, Last):		DOB:
Health Plan:	Member ID:	Group #:

SECTION 2. ORDERING PROVIDER INFORMATION

Physician Name (First, Last):		
Primary Specialty:	NPI:	Tax ID:
Phone #:	Fax #:	Contact Name:

SECTION 3. FACILITY INFORMATION

Facility Name:	Facility Tax ID:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Date of Service:	

SECTION 4. EXAM REQUEST

☐ MPI ☐ Stress Echo ☐ MUGA ☐ TTE ☐ TEE ☐ Fetal Echo

CPT Code(s):

Description:

ICD Diagnosis Code(s):

Description:

Date of first office visit for this condition with any provider:

Date of most recent office visit for this condition with any provider:

SECTION 5. SELECT APPLICABLE STUDY AND CHECK REASON(S) FOR EVALUATION *(CHECK ALL THAT APPLY)*

☐ **MPI** ☐ **STRESS ECHO** ☐ **MUGA** ☐ **Cardiac MRI** ☐ **Coronary CTA**

☐ Preoperative Evaluation ☐ Post Operative Evaluation ☐ Evaluation during or Prior to Chemotherapy

☐ Patient has physical limitation to exercise

Chest Pain or suspected Angina with:
(Check all that apply)

- ☐ Without other symptoms
- ☐ Exacerbated by exercise or relieved by rest
- ☐ Relieved with Nitroglycerin
- ☐ Dyspnea (Shortness of Breath)
- ☐ Jaw Pain
- ☐ Left Arm Pain/Radiating Pain
- ☐ Retrosternal Location

Associated Conditions:
(Check all that apply)

- ☐ Abnormal EKG
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Known CAD
- ☐ New Onset Heart Failure
- ☐ Patient has one or more of the following: heart transplant, aortic aneurysm, and/or carotid narrowing/stenosis

Other Indications:
(Check all that apply)

- ☐ Abnormal Test Results *(Please provide detail in previous test grid below)*
- ☐ Anomalous coronary artery
- ☐ Congenital heart disease (known/suspected)
- ☐ Evaluation for myocardial viability
- ☐ Pediatric Acquired Heart Disease
- ☐ Suspected Constrictive Pericarditis
- ☐ Quantification intracardiac shunt
- ☐ Quantification valvular regurgitation

Risk Factors for Coronary Artery Disease: *(Check all that apply)*

- ☐ Age greater than 40
- ☐ CAD/MI in a father, brother, son <50 years old
- ☐ CAD/MI in a mother, sister, daughter <60 years old
- ☐ Current Smoker
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Hypertension
- ☐ Other (describe): _____

(continued on next page)

Previous Tests	Date	Results
☐ Exercise Stress Test		
☐ Myocardial Perfusion Imaging (MPI) ☐ PET ☐ SPECT		
☐ Stress Echocardiogram		
☐ Cardiac MRI		
☐ Cardiac Catheterization		
☐ Coronary CTA		
☐ EKG		
☐ Other		

☐ TTE (Transthoracic Echo) ☐ TEE (Transesophageal Echo) ☐ Fetal Echo

Reason for Study *(Check all that apply)*

- ☐ Abnormal Test Results (provide details below)
- ☐ Acquired Pediatric Heart Disease
- ☐ Aortic Disease
- ☐ Arrhythmias
- ☐ Congenital Heart Disease
- ☐ Device Evaluation (Pacemaker, ICD, or CRT)
- ☐ Evaluate for cardiomyopathy (known/suspected)
- ☐ Known or Suspected Fetal Cardiac Disorder
- ☐ Murmur or click
- ☐ Pericardial Disease
- ☐ Pulmonary Hypertension
- ☐ Pre-op
- ☐ Post-op
- ☐ Suspected Cardiac Mass
- ☐ Suspected or Known Endocarditis
- ☐ Valvular Disease
- ☐ Ventricular Function
- ☐ Other (describe): _____

Symptoms with Suspected Cardiac Etiology *(Check all that apply)*

- ☐ Assess for structural heart disease
  - ☐ Chest Pain
  - ☐ Dyspnea (Shortness of Breath)
  - ☐ Palpitations
  - ☐ Syncope
- ☐ Suspected Cardiac Source of Embolus
  - ☐ Peripheral Embolic Event
  - ☐ TIA /Stroke
- ☐ ADL Limitations (list): _____
- ☐ Other (describe): _____

Previous Tests	Date	Results
☐ TTE		
☐ TEE		
☐ Myocardial Perfusion Imaging (MPI)		
☐ MUGA		
☐ Cardiac MRI/CT		
☐ Coronary CTA		
☐ EKG		
☐ Other		

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.