

CIGNA HealthCare - Ampyra -

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		
Specialty:	* DEA or TIN:		asterisked (*) items on this form are completed**		
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? * May we fax our response to your office? Yes No Yes No			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested: (please specify name, strength, and dosing schedule):					
☐ Ampyra 10mg ☐ Other (please specify):					
Diagnosis related to use:					
☐ multiple sclerosis (MS) ☐ Other (please specify):					
Will this medication be used to improve the patient's walking? Yes ☐ No ☐					
Duration of therapy:					
Formulary alternatives tried: (please include length of trial and/or if samples were given):					
Additional pertinent information: (please include clinical reasons for drug, relevant lab values, etc.):					
CIGNA HealthCare's coverage positions may be viewed online at:					

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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