CIGNA®

Pharmacy Services

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

CIGNA HealthCare Prior Authorization Form
- PegaSys, Copegus, Peg-Intron, Rebetol, Infergen -

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:	* NPI, 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: *(please check all that apply):*

PegaSys:	☐ 180mcg/ml vial	☐ 180mcg/ml kit	☐ 180mcg/0.5ml kit	
Peg-Intron:	☐ 50mcg/0.5ml vial	☐ 80mcg/0.5ml kit	☐ 120mcg/0.5ml kit	☐ 150mcg/0.5ml kit
Ribavirin:	☐ 200mg capsule	☐ 40mg/ml solution		
Copegus:	☐ 200mg tablet			
Infergen:	☐ 9mcg/0.3ml vial	☐ 15mcg/0.5ml vial		

Other (*please specify*):

Dose and Frequency: Expected Duration: J-Code:

Where will this medication be obtained?

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

Clinical Data:

Diagnosis related to use: ☐ Hepatitis C ☐ Hepatitis B ☐ Other *(please specify):*

Does this patient have an HIV co-infection? ☐ Yes ☐ No

For Infergen requests only:

Did the patient have intolerance to treatment with PegaSys or Peg-Intron? ☐ Yes ☐ No

If diagnosis is Hepatitis C, please complete the following questions:

What is the patient's Genotype?

☐ Type 1 ☐ Type 2 ☐ Type 3 ☐ Type 4 ☐ Type 5 ☐ Type 6 ☐ Genotype unknown

What is the individual's current weight?

Does this individual have compensated liver disease?	☐ Yes	☐ No
Does this patient have bridging fibrosis?	☐ Yes	☐ No
Does this patient have cirrhosis?	☐ Yes	☐ No
Does this patient have steatosis?	☐ Yes	☐ No

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Has the patient already started treatment on the requested medication? ☐ Yes ☐ No

If yes, what date did treatment begin? *(please specify):*

Lab values:

Please specify the patient's Quantitative HCV RNA value at each of the following phases of treatment.
(Please note that at initiation of therapy CIGNA Pharmacy Services only needs the patient's pre-treatment lab values; subsequent values should be obtained throughout the patient's treatment).

Treatment Phase	Date lab assessed	Lab Value (in IU/ml)
Pre-treatment		
12 weeks – 16 weeks		
24 weeks – 28 weeks		
Other:		
Other:		
Post treatment (24 weeks after end of therapy for documentation of sustained virologic response)		

Helpful Tips for the Prescriber –

Based on the patient's genotype and lab values, CIGNA Pharmacy Services may authorize the requested medication for a partial duration of the prescribed treatment. In many cases, re-authorization is contingent upon the patient's therapeutic response to the medication. If your request for authorization is approved, we will mail or fax you a letter indicating the duration of approval and the requirements for re-approval.

To make re-authorization as efficient as possible, we recommended that you keep a copy of this prior authorization form in the patient's chart and update it with recent lab values when requesting a new authorization. By updating the lab values and re-faxing this form to us, we will be able to review the request for additional coverage.

Additional pertinent information:

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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