



**CIGNA**

**Pharmacy Services**

Phone: (800)244-6224

Fax: (800)390-9745

# CIGNA HealthCare Prior Authorization Form - Synvisc, Hyalgan, Supartz, Orthovisc -

**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:		
<b>Medication requested:</b>					
<input type="checkbox"/> Synvisc <input type="checkbox"/> Hyalgan <input type="checkbox"/> Supartz <input type="checkbox"/> Orthovisc <input type="checkbox"/> Other (please specify):					
Dose and Quantity:		Duration of therapy:		J-Code:	
<b>Where will this medication be obtained?</b>					
<input type="checkbox"/> CIGNA Tel-Drug (CIGNA's nationally preferred specialty pharmacy)			<input type="checkbox"/> Retail pharmacy		
<input type="checkbox"/> Prescriber's office stock (billing on a medical claim form)			<input type="checkbox"/> Home Health / Home Infusion vendor		
<input type="checkbox"/> Other (please specify):					
<b>Clinical Data:</b>					
Diagnosis related to use (please specify):					
Does this patient have painful osteoarthritis of the knee? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Which prior analgesic medications (including acetaminophen, NSAIDs and COX-II Inhibitors) has the patient tried? Please provide the medication name, dose, dates of use, and please note any adverse effects of medications:					
Does this patient have a contraindication to analgesics (such as acetaminophen, NSAIDs or COX-II Inhibitors)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, please specify the contraindication:					
Please note any conservative non-pharmacologic therapies tried (for example, physical therapy, etc.):					
<b>Additional pertinent information:</b>					

**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](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>.*