Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Avsola (infliximab-axxq)
Inflectra (infliximab-dyyb)
Remicade (infliximab)
Renflexis (infliximab-adba)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician 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, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:

☐ Avsola 100mg vial
☐ infliximab 100mg vial
☐ Renflexis 100mg vial
☐ Inflectra 100mg vial
☐ Remicade 100mg vial
☐ Other (*please specify*):

Directions for use: Dose: Quantity: Duration of therapy:

What is your patient's current weight?

Is this a new start or continuation of therapy? If changing from one infliximab product to another, please choose "new start of therapy". If your patient has already begun treatment with drug samples of Avsola, Inflectra, infliximab, Remicade or Renflexis, please choose "new start of therapy".

☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a beneficial response to infliximab (Avsola, Inflectra, Remicade [or its authorized generic, infliximab], Renflexis)? ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of the requested drug:

Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ Other

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):

☐ Ankylosing Spondylitis (AS, axial spondyloarthropathy)
☐ Behcet's disease
☐ Crohn's Disease (CD, regional enteritis)
☐ Graft Versus Host Disease (GVHD)
☐ Hidradenitis Suppurativa (HS)
☐ Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor* Therapy (*Bavencio, Imfinzi, Keytruda, Opdivo, Tecentriq, Yervoy)
☐ Indeterminate Colitis
☐ Non-Radiographic Axial Spondyloarthritis
☐ Plaque Psoriasis (CPP, PsO, psoriasis vulgaris)
☐ Polyarticular juvenile idiopathic arthritis (pJIA) (includes Juvenile Rheumatoid Arthritis, Juvenile Spondyloarthropathy/Active Sacroiliac Arthritis)
☐ Psoriatic Arthritis (PsA)
☐ Pyoderma Gangrenosum (PG)
☐ Rheumatoid Arthritis (RA)
☐ Sarcoidosis
☐ Scleritis or Sterile Corneal Ulceration
☐ Spondyloarthritis (non-axial disease): Reactive Arthritis (Reiter's disease) and Undifferentiated Arthritis
☐ Still's disease
☐ Ulcerative Colitis (UC)
☐ Uveitis (includes other posterior uveitides and panuveitis syndromes)
☐ other:

(if other) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

(if AS) Has the patient already received a biologic for their condition? ☐ Yes ☐ No

(if AS) The covered alternative is one non-steroidal anti-inflammatory drug (NSAID). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if AS) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if AS, Non-Radiographic Axial Spondyloarthritis, pJIA, RA, Spondyloarthritis, Still's disease) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if Behcet's disease) Has the patient already received a biologic for their condition? ☐ Yes ☐ No

(if Behcet's disease) The covered alternative is one systemic conventional therapy. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Behcet's disease) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Behcet's disease) Does the patient have ophthalmic manifestations of Behcet's disease? ☐ Yes ☐ No

(if Behcet's disease) Is this drug being prescribed by, or in consultation with, a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist? ☐ Yes ☐ No

(if CD) Has the patient already received a biologic for their condition? ☐ Yes ☐ No

(if CD) Does the patient meet ONE of these?
☐ Severe disease needing hospitalization
☐ Involvement of the UPPER GI tract
☐ Patient is a Smoker
☐ Patient is LESS THAN 40 years of age
☐ Stricturing disease
☐ Perianal disease
☐ Other enterocutaneous fistula
☐ Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
☐ Previous Crohn’s disease-related surgery (for example, ileocolonic resection (to reduce the chance of Crohn’s disease recurrence)
☐ Bowel obstruction
☐ History of abscess or perforation (after healing)
☐ MORE THAN 1 of the above
☐ None of the above

(if CD) The covered alternative is one corticosteroid, or a corticosteroid will be taken concurrently with infliximab. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if CD) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a corticosteroid concurrently with infliximab
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if CD) The covered alternative is one other conventional systemic therapy, or a conventional systemic therapy will be taken concurrently with infliximab. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if CD) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient will take a conventional systemic therapy concurrently with infliximab
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if CD) Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

(if GVHD) The covered alternative is one conventional systemic therapy (for example, corticosteroids, antithymocyte globulin, other immunosuppressants). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if GVHD) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if GVHD) Is this drug being prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

(if HS) The covered alternative is one conventional therapy (examples of conventional therapy: intralesional corticosteroids or systemic antibiotics). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if HS) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if HS) Is this drug being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

(if checkpoint inhibitor) Was your patient receiving a checkpoint inhibitor (for example, Bavencio, Imfinzi, Keytruda, Opdivo, Tecentriq, or Yervoy)? ☐ Yes ☐ No

(if checkpoint inhibitor) Did your patient develop an immunotherapy-related toxicity OTHER THAN hepatitis? ☐ Yes ☐ No

(if checkpoint inhibitor, Sarcoidosis) The covered alternative is one systemic corticosteroid. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if checkpoint inhibitor, Sarcoidosis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if checkpoint inhibitor) Is this drug being prescribed by, or in consultation with, an oncologist, gastroenterologist, rheumatologist, or ophthalmologist? ☐ Yes ☐ No

(if Indeterminate colitis) The covered alternatives are: a. Systemic corticosteroid; b. Mesalamine; c. One of the following: i. Azathioprine, or ii. 6-mercaptopurine. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if Indeterminate colitis) For Systemic corticosteroid, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Indeterminate colitis) For Mesalamine, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Indeterminate colitis) For Azathioprine or 6-mercaptopurine, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Indeterminate colitis) Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

(if Non-Radiographic Axial Spondyloarthritis) Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if Non-Radiographic Axial Spondyloarthritis) The covered alternative is one non-steroidal anti-inflammatory drug (NSAID). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Non-Radiographic Axial Spondyloarthritis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Non-Radiographic Axial Spondyloarthritis) Was the patient's lab test for C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

(if Non-Radiographic Axial Spondyloarthritis) Has the patient been reported to have Sacroiliitis on their MRI? ☐ Yes ☐ No

(if Non-Radiographic Axial Spondyloarthritis) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if Plaque Psoriasis) Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if Plaque Psoriasis) The covered alternatives are: A. Topical therapy (for example, topical corticosteroids, topical vitamin D analogs, Tazorac); B. Systemic therapy (for example, methotrexate, cyclosporine, Soriatane); C. Phototherapy. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if Plaque Psoriasis) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

(if Plaque Psoriasis) Does your patient have ONE of the following?
☐ Affected BSA (body surface area) is greater than 5%
☐ Affected BSA is less than 5% AND the following area(s) are involved: scalp, face, the palms and soles (palmoplantar disease), or genitals
☐ None of the above

(if Plaque Psoriasis) Is this drug being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

(if PG) Is this drug being prescribed by, or in consultation with, a rheumatologist or a dermatologist? ☐ Yes ☐ No

(if PG) The covered alternative is conventional systemic therapy (for example, mycophenolate mofetil, cyclosporine or corticosteroid). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug,

please provide details why your patient can't try this alternative.

(if PG) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if PsA) Is this drug being prescribed by, or in consultation with, a rheumatologist or a dermatologist? ☐ Yes ☐ No

(if pJIA) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if RA) Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if RA) The covered alternative is one conventional synthetic disease-modifying anti-rheumatic drug (csDMARD). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if RA) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if RA) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if Sarcoidosis) The covered alternative is one systemic corticosteroid. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Sarcoidosis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Sarcoidosis) The covered alternative is one immunosuppressant other than a systemic corticosteroid. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Sarcoidosis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Sarcoidosis) Is this drug being prescribed by, or in consultation with, a pulmonologist, ophthalmologist or dermatologist?
☐ Yes ☐ No

(if Scleritis or Sterile Corneal Ulceration) The covered alternative is one ophthalmic or systemic immunosuppressant therapy. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Scleritis or Sterile Corneal Ulceration) Per the information provided above, which of the following is true for your patient in regard to

the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Scleritis or Sterile Corneal Ulceration) Is this drug being prescribed by, or in consultation with, an ophthalmologist? ☐ Yes ☐ No

(if Spondyloarthritis) Has the patient already received a biologic for non-axial spondyloarthritis? ☐ Yes ☐ No

(if Spondyloarthritis) The covered alternative is one conventional synthetic disease-modifying anti-rheumatic drug (csDMARD). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Spondyloarthritis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Spondyloarthritis) Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? ☐ Yes ☐ No

(if Spondyloarthritis) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if Still's disease) Has the patient already received a biologic for Still’s Disease? ☐ Yes ☐ No

(if Still's disease) The covered alternative is one corticosteroid. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Still's disease) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Still's disease) The covered alternative is one conventional synthetic disease-modifying antirheumatic drug (DMARD). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Still's disease) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative for AT LEAST 2 MONTHS, but it didn't work.
☐ The patient tried the alternative, for AT LEAST 2 MONTHS, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Still's disease) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if UC) Has the patient already received a biologic or targeted synthetic DMARD (tsDMARD) for Ulcerative Colitis? ☐ Yes ☐ No

(if UC) Does the patient have pouchitis and has tried therapy with an antibiotic, corticosteroid enema or suppository, or mesalamine enema or suppository? ☐ Yes ☐ No

(if UC) The covered alternative is one conventional systemic therapy. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if UC) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?

☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if UC) Is this drug being prescribed by, or in consultation with, a gastroenterologist? ☐ Yes ☐ No

(if Uveitis) Has the patient already received a biologic for Uveitis? ☐ Yes ☐ No

(if Uveitis) The covered alternative is one ophthalmic or systemic immunosuppressant therapy. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if Uveitis) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if Uveitis) Is this drug being prescribed by, or in consultation with, an ophthalmologist or rheumatologist? ☐ Yes ☐ No

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v031524