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

Duopa
(carbidopa and levodopa enteral suspension)

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:
Duopa: ☐ ☐ Other *(please specify)*: ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***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):

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: ☐ advanced Parkinson's disease ☐ Other *(please specify)*:

Clinical Information:
Is this new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Is there documentation your patient has had a beneficial response to Duopa? ☐ Yes ☐ No

Is your patient experiencing 3 or more hours of "Off" time on their current Parkinson's disease drug treatment? "Off" time is defined as a return of parkinsonian symptoms before the onset of the next dose. ☐ Yes ☐ No
Has your patient had a previous positive clinical response to treatment with oral levodopa (Rytary, Sinemet, Sinemet CR, Stalevo)? ☐ Yes ☐ No

The covered alternative is oral carbidopa and levodopa (Immediate Release or Controlled Release). Examples include: Rytary, Sinemet, Sinemet CR, Stalevo. 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.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough
☐ The patient is able to try the alternative, but has not done so yet
☐ 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

The covered alternatives are two other therapies for "Off" episodes such as: A. entacapone (generic Comtan); B. rasagiline (generic Azilect); C. pramipexole (generic Mirapex); D. ropinirole (generic Requip); E. tolcapone (generic Tasmar); F. cabergoline (generic Dostinex); G. oral selegiline (generic Eldepryl). 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.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

- ☐ The patient tried TWO of the alternatives, but none of these drugs worked well enough
- ☐ The patient tried TWO of the alternatives, but they did not tolerate them
- ☐ The patient cannot try TWO of these alternatives because of a contraindication to each of these drugs
- ☐ Other

For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has; inability to administer the covered alternative and requires this dosage formulation].

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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.

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