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

Zilretta
(triamincinolone acetonide extended release 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:
Zilretta 32mg vial: ☐ Quantity:

Duration of therapy: J-Code: ICD10:

Dose: Frequency of therapy:

Please specify site of injection for this request:
☐ left knee
☐ right knee
☐ both knees

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

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

Diagnosis related to use:
☐ osteoarthritis pain of the knee
☐ Other (please specify)

Clinical Information:

Has your patient's diagnosis of the knee to be treated been confirmed by radiologic evidence (examples include diagnosis based on x-ray, magnetic resonance imaging, computed tomography scan, and ultrasound)? ☐ Yes ☐ No

Has your patient tried at least one intraarticular corticosteroid injection in the knee to be treated (examples include immediate-release triamcinolone acetonide, betamethasone sodium phosphate/betamethasone acetate, dexamethasone sodium phosphate, and methylprednisolone acetate)? ☐ Yes ☐ No

Is your patient receiving re-treatment of the knee (or knees) that were previously treated with this medication? ☐ Yes ☐ No

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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005