Cigna®

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

iDose TR
(travoprost implant)

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: ☐ iDose TR 75 mcg implant

Directions for use: Quantity:

ICD10:

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):

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):
☐ Ocular Hypertension
☐ Open-Angle Glaucoma
☐ Other (Please specify):

Clinical Information:

The covered alternatives are: ophthalmic prostaglandins either as monotherapy or as concomitant therapy (Examples of ophthalmic prostaglandins include bimatoprost 0.03% ophthalmic solution, latanoprost 0.005% ophthalmic solution, travoprost 0.004% ophthalmic solution; Lumigan [bimatoprost 0.01% ophthalmic solution], Vyzulta [latanoprostene bunod 0.024% ophthalmic solution], Xelpros [latanoprost 0.005% ophthalmic emulsion], tafluprost 0.0015% ophthalmic solution, Iyuzeh [latanoprost 0.005% ophthalmic solution], and Omlonti [omidenepag isopropyl 0.002% ophthalmic solution]). 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 regard to the covered alternatives?
☐ The patient tried 2 of the alternatives, but none of these drugs worked well enough.
☐ The patient tried 2 of the alternatives, but experienced adverse event(s) severe enough to warrant discontinuation.
☐ Other

The covered alternatives are: other ophthalmic products (either as monotherapy or as concomitant therapy) from different pharmacological classes for the treatment of your condition not including ophthalmic prostaglandins (for example, beta-blockers, alpha-agonist [brimonidine], carbonic anhydrase inhibitors, and rho kinase inhibitor [netarsudil]). 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 regard to the covered alternatives?
☐ The patient tried 2 of the alternatives from different classes, but none of these drugs worked well enough.
☐ The patient tried 2 of the alternatives, but experienced adverse event(s) severe enough to warrant discontinuation.
☐ Other

Is the requested medication to be administered by, or under the supervision of an ophthalmologist? ☐ Yes ☐ No

For which eye(s), will the requested medication be inserted into?
☐ Right eye
☐ Left eye
☐ Both eyes

Is the patient receiving re-treatment in the same eye(s) noted in the previous question with the requested medication? ☐ Yes ☐ No

Will the patient also be using Durysta (bimatoprost intracameral implant) in the same eye(s) as the requested medication? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

Additional pertinent information: *(including prior therapy, disease stage, 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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