Cigna®

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

Medication Prior Authorization Form

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name: Shiva Pedram, MD			*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: Pediatric Gastroenterology	* DEA or TIN: 12345678		* Patient Name: Sarah Sample		
Office Contact Person: Pablo Salvador Lopez			* Cigna ID: 4567890	* Date of Birth: 10-19-2014	
Office Phone: 555-991-2750			* Patient Street Address: 25 W Randolph St		
Office Fax: 555-786-5643			City: Chicago	State: IL	Zip: 60601
Office Street Address: 5721 S Maryland Ave			Patient Phone: 555-123-4567		
City: Chicago	State: IL	Zip: 60637			

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: (*please specify name, strength, and dosing schedule)*
Adalimumab 40mg

160 mg (given as four 40 mg injections on day 1) followed by 80 mg (given as two 40 mg injections) two weeks later. 40mg every other week starting 2 weeks from 2nd dose.

Duration of therapy: 6 months

Quantity: 16 injections

Diagnosis related to use: Crohn's Disease

[For pain medications only]: Does the patient have a terminal illness? ☐ Yes ☒ No

Alternative Medications:
Has your patient ever received the **generic** alternative of the requested medication?
☐ Yes ☒ No ☐ No generic available
(if yes) Did your patient try more than one manufacturer of this generic? ☐ Yes ☐ No ☐ Unavailable

Please provide the following details for each trial: manufacturer name, date(s) taken and for how long, and what the documented results were of taking the drug, including any intolerances or adverse reactions your patient experienced.
(please note that the manufacturer's information can be obtained through the dispensing pharmacy):

Drug Name	Dates taken & how long	Documented results, including intolerances/adverse reactions the patient experienced

Has your patient ever received any other **alternative treatments for this diagnosis**? ☒ Yes ☐ No
(if yes) Please provide the following details: 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:

Drug Name	Dates taken & how long	Documented results, including intolerances/adverse reactions the patient experienced
Methylprednisone	10/10/24 - 10/19/24	Patient continued to have bloody stools and abdominal pain with no improvement

(if no to any question above) Is your patient able to use any other alternatives for this diagnosis? ☐ Yes ☐ No

(if no) Please provide the reason(s) why your patient is unable to use the available alternative(s):

Additional pertinent information: (*please include other clinical reasons for drug, relevant lab values, etc.)*

Please see attached clinical notes, lab results, and imaging results.
Patient has evidence of new diagnosis of Crohn's disease, is currently hospitalized due to a flare and is not improving on standard therapy (methylprednisone).

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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