Cigna®

Fax completed form to: (855) 840-1678

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:

Please specify site of injection for this request:

☐ left knee
☐ right knee
☐ both knees
☐ Other (please specify):

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

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
☐ osteoarthritis pain in joints OTHER THAN the knee
☐ Other

Clinical Information:

Was the patient's diagnosis confirmed by radiologic evidence (for example, x-ray, magnetic resonance imaging, computed tomography scan, and ultrasound)? ☐ Yes ☐ No

The covered alternative is one immediate-release intraarticular corticosteroid injection in the knee to be treated (for example, immediate-release triamcinolone acetonide, betamethasone sodium phosphate and betamethasone acetate, dexamethasone sodium phosphate, and methylprednisolone acetate). If your patient has tried this drug/treatment, 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/treatment, 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 had a significant intolerance to it.
☐ The patient can't try the alternative because of one of the following: contraindication according to the FDA label; a warning per the

prescribing information (labeling); a disease characteristic or clinical factor the patient has.
☐ Other

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of this drug, please choose "new start of therapy".
☐ New start of therapy
☐ Continuation of therapy

(if continuation of therapy) Has the patient already been injected with Zilretta in the affected knee? ☐ Yes ☐ No
Notes: Re-treatment of knee(s) previously treated with Zilretta is considered experimental, investigational or unproven.

(if yes or unknown) Please provide clinical support for continued use of the requested medication in your patient.

Please provide any additional clinical information that you feel is important to this review, including if the patient is currently taking the requested drug, including how they've been receiving it (samples, paying out of pocket, etc.) and how long they been on it with dates.

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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