



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

# Durysta (bimatoprost ophthalmic 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:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> 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)					
<b>Medication Requested:</b> <input type="checkbox"/> Durysta 10mcg implant			ICD10:		
Directions for use:			Quantity:		
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):					
			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <b>**Cigna's nationally preferred specialty pharmacy</b>		
<i>**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</i>					
<b>Facility and/or doctor dispensing and administering medication:</b> 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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Diagnosis:</b> <input type="checkbox"/> open-angle glaucoma <input type="checkbox"/> ocular hypertension <input type="checkbox"/> Other (Please specify): _____					
<b>Clinical Information:</b> Is the patient receiving re-treatment of the eye(s) previously treated with Durysta? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> Will Durysta be used concurrently with iDose TR (travoprost intracameral implant)? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> Has the patient tried at least two ophthalmic prostaglandins (either as monotherapy or as concomitant therapy) for the treatment of open-angle glaucoma or ocular hypertension? Please Note: 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 (omidenedepag isopropyl 0.002% ophthalmic solution). <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> Has the patient tried at least two other ophthalmic products (either as monotherapy or as concomitant therapy) from two different pharmacological classes for the treatment of open-angle glaucoma or ocular hypertension? Please Note: Examples of pharmacological classes of ophthalmic products for the treatment of open-angle glaucoma or ocular hypertension include beta-blockers, alpha-agonist (brimonidine), carbonic anhydrase inhibitors, and rho kinase inhibitor (netarsudil). <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					

According to the prescriber, has the patient had inadequate efficacy to the previously-tried ophthalmic products? Yes  No

(if no) Has the patient experienced adverse event(s) severe enough to warrant discontinuation of the previously-tried ophthalmic products, according to the prescriber? Yes  No

Is the requested medication being administered by or under the supervision of an ophthalmologist? Yes  No

How many eyes are being treated?

- One eye  
 Both eyes

**Additional pertinent information:**

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:** \_\_\_\_\_

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*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](http://cigna.com).*

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