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
☐ All Other indications or diagnoses

Clinical Information:

Is the patient receiving re-treatment of previously treated eye(s) within one year? ☐ Yes ☐ No

Is iDose TR being used concurrently with Durysta (bimatoprost intracameral implant)? ☐ Yes ☐ No

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 (omidenepag isopropyl 0.002% ophthalmic solution). ☐ Yes ☐ No

(if yes) 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). ☐ Yes ☐ No

(if yes) According to the prescriber, for each of the ophthalmic medications that was tried (at least two ophthalmic prostaglandins AND at least two other ophthalmic products from two different pharmacological classes),has the patient had inadequate efficacy to the previously tried ophthalmic products? ☐ Yes ☐ No

(if no) According to the prescriber, for each of the ophthalmic medications that was tried (at least two ophthalmic prostaglandins AND at least two other ophthalmic products from two different pharmacological classes), has the patient experienced adverse event(s) severe enough to warrant discontinuation of the previously tried ophthalmic products? ☐ Yes ☐ No

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

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.

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