

# MEDICARE ADVANTAGE DRUGS/BIOLOGICS PART B PRECERTIFICATION FORM



PART B STEP THERAPY - DUROLANE, EUFLEXXA, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SODIUM HYALURONATE 1%, SUPARTZ FX, SYNOJOYNT, TRILURON, TRIVISC, VISCO-3

This precertification form applies to all Cigna Medicare markets except Leon health plans. This precertification form does not apply to Medicaid only and Medicare/Medicaid Plan (MMP) plans. Please fax to: **1-877-730-3858** | Phone: **1-888-454-0013**

Note: In an effort to process your request in a timely manner, please submit all pertinent clinical information.

<input type="checkbox"/> <b>Expedited – defined as danger to a patient’s health if not provided within 24 hours</b>		
Patient name:		Patient date of birth:
Name of requesting provider:		ID number:
Contact person:		Date of service:
Address:		
NPI number:	Phone number:	Fax number:

<b>If referring to a (servicing) provider, the below stated information must be submitted:</b>	
Name of servicing provider:	Phone number:
Contact person:	Fax number:
Address:	NPI number:
<input type="checkbox"/> Please check if servicing provider is non-contracted If servicing provider is non-contracted/out-of-network provider/facility, please explain why:	
Who will supply the medication? <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient hospital/clinic <input type="checkbox"/> Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes: <input type="checkbox"/> Provider office <input type="checkbox"/> Outpatient hospital/clinic <input type="checkbox"/> Other. Please specify:
Diagnosis codes:	Diagnosis:

**Please attach all required documentation: recent clinical notes, copy of the prescription or physician order, relevant diagnostic labs.**

HCPDS codes	Drug name (if applicable)	Dose (if applicable)	Frequency	Duration

Q1: Is this a new start or a continuation of therapy within the past 365 days?

Q2: Has the patient had an intolerance or an inadequate response to a Step 1 alternative Monovisc, Orthovisc, Synvisc, or Synvisc One\*?

Q3: If patient is unable to try a Step 1 alternative Monovisc, Orthovisc, Synvisc, or Synvisc One\*, please provide the reason(s) why an exception should be made to the step therapy requirement:

\*Cigna requires precertification for Step 1 alternative - Monovisc, Orthovisc, Synvisc, or Synvisc One