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

BAL in Oil (dimercaprol) Edetate Calcium Disodium (calcium disodium versenate, calcium EDTA)

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:
☐ BAL in Oil 10% oil for injection ☐ Calcium Disodium Versonate 1000mg/5mL solution for injection
☐ other (please specify):

Directions for use: Dosing and Quantity: Duration of therapy:
J-Code ICD10:

Is this a new start or continuation of therapy? ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has the patient already received 10 days of treatment since starting this cycle of therapy? ☐ Yes ☐ No

(if no) How many days of treatment remain?

(if 10 or more days of treatment) How much longer is patient going to be taking and why does the patient still need this treatment?

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***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

What is your patient's diagnosis?
☐ Arsenic, gold, or mercury overload or toxicity
☐ acute lead poisoning
☐ acute poisoning by mercury salts
☐ atherosclerotic vascular disease
☐ autism spectrum disorder
☐ chronic lead poisoning (including lead encephalopathy)
☐ mercury toxicity from dental amalgam fillings

☐ (if requesting BAL in Oil) other heavy metal poisoning (caused by other heavy metals including antimony, bismuth, iron, cadmium, or selenium)
☐ (if requesting edetate calcium disodium) other heavy metal poisioning (caused by other heavy metals including aluminum, arsenic, cadmium, cobalt, manganese, mercury, plutonium, or uranium)
☐ Other (please specify):

Clinical Information

if requesting BAL in Oil and arsenic, gold, mercury overload or toxicity) Have lab results (for example, blood, plasma, and/or urine) or clinical findings confirmed or been consistent with toxicity? ☐ Yes ☐ No

(if requesting BAL in Oil and acute lead poisoning) Will this medication be taken in combination with Edetate Calcium Disodium (EDTA)? ☐ Yes ☐ No

(if acute or chronic lead poisoning) Is the patient's blood lead level greater than 44 micrograms/deciliter (µg/dL)? ☐ Yes ☐ No

(if BAL in Oil and acute poisoning by mercury salts) Is/Was therapy (being) started 2 hours or less after the ingestion? ☐ Yes ☐ No

Additional Pertinent Information(examples could include past medications tried, labs, pertinent patient history, and names 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.

v010124