



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare - Medication Prior Authorization Form -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider 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 or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/> * May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested: <i>(please specify name, strength, and dosing schedule):</i>					
Diagnosis related to use:					
Duration of therapy:					
Formulary alternatives tried: <i>(please include length of trial and/or if samples were given):</i>					
Additional pertinent information: <i>(please include clinical reasons for drug, relevant lab values, etc.):</i>					
Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.					
<i>Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.</i>					

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