Medication Prior Authorization Form

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

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: (*please specify name, strength, and dosing schedule)*

Duration of therapy: Quantity: ICD10:

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:

Alternative Medications:
Has your patient ever received the **generic** alternative of the requested medication?
☐ Yes ☐ No ☐ No generic available
(if yes) Did your patient try more than one manufacturer of this generic? ☐ Yes ☐ No ☐ Unavailable

Please provide the following details for each trial: manufacturer name, date(s) taken and for how long, and what the documented results were of taking the drug, including any intolerances or adverse reactions your patient experienced.
(please note that the manufacturer's information can be obtained through the dispensing pharmacy):

Drug Name	Dates taken & how long	Documented results, including intolerances/adverse reactions the patient experienced

Has your patient ever received any other **alternative treatments for this diagnosis**? ☐ Yes ☐ No
(if yes) Please provide the following details: date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced:

Drug Name	Dates taken & how long	Documented results, including intolerances/adverse reactions the patient experienced

(if no to any question above) Is your patient able to use any other alternatives for this diagnosis? ☐ Yes ☐ No
(if no) Please provide the reason(s) why your patient is unable to use the available alternative(s):

Additional pertinent information: (*please include other clinical reasons for drug, relevant lab values, etc.)*

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.

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