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 ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

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

Diagnosis related to use:

Duration of therapy:

Formulary alternatives tried: (*please include length of trial and/or if samples were given)*:

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

CIGNA HealthCare's coverage positions may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

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.

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