Medication Prior Authorization Form

Phone: (800) 244-6224
Fax: (800) 390-9745

Notice: Please be sure to complete this form in its entirety. Missing information makes it difficult to approve requests and creates a longer processing time.

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 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:		

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.)*

Please fax completed form to (800) 390-9745. Urgent 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 us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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