



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Narcotic Medications -

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"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
Strength & Dose:			Expected Duration:		
Please explain the dosing / titration plan (if applicable):					
Clinical Data:					
Diagnosis related to use (<i>please specify</i>):					
Type of Pain (<i>please specify</i>):					
<input type="checkbox"/> Visceral	<input type="checkbox"/> Neuropathic	<input type="checkbox"/> Musculo-skeletal	<input type="checkbox"/> Cancer	<input type="checkbox"/> Psychogenic	
<input type="checkbox"/> Other (<i>please specify</i>):					
Is this patient in hospice care (or do they meet hospice enrollment criteria)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has this patient been seen by a pain specialist?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has this patient been evaluated by a behavioral health provider?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Please describe the nature of the pain in terms of intensity and character by indicating the following:					
Onset and temporal pattern:					
Location:					
Description:					
Intensity:					
Aggravating factors:					
Relieving factors:					
Is there functional impairment caused by the pain?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please describe:					
Have any non-pharmacological treatments been used?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If YES, please specify:					
<input type="checkbox"/> Self-management techniques	<input type="checkbox"/> Physical Therapy/Rehab				
<input type="checkbox"/> Behavioral treatment	<input type="checkbox"/> Other (<i>please specify</i>):				

Clinical Data (continued):

Please provide any pertinent details regarding the outcome of these treatments:

What pain medications have already been tried?

(Please include dates of therapy, strength, dosage, and reason for discontinuation):

If no prior pain medications have been tried, please explain the clinical reason for using this medication, at this dosage, as first-line therapy:

Additional pertinent clinical information:

**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>.

V 041510

"CIGNA Pharmacy Management" or "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and HMO or service company subsidiaries of CIGNA Health Corporation.