



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare

- Compound Medication Prior Auth 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"/>			* 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: (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):					
Compound Ingredient Information					
	Drug Name	NDC	Quantity	Cost	
Ingredient #1					
Ingredient #2					
Ingredient #3					
Ingredient #4					
Ingredient #5					
Ingredient #6					
Ingredient #7					
Ingredient #8					
Ingredient #9					
Ingredient #10					
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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