



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Selzentry -

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:

Selzentry Strength & Dose (please specify):

Clinical Information:

What is the patient's diagnosis?

Is the patient CCR5-tropic HIV-1 positive? Yes No
If yes, was the diagnosis confirmed by a co-receptor tropism assay? Yes No

Has there been a resistance to multiple antiretroviral agents? Yes No

Will this medication be used in combination with other antiretroviral medications? Yes No

Does the patient show evidence of viral replication? Yes No

Additional Information:

**CIGNA HealthCare's coverage position on this and other medications 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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