DRUGS/BIOLOGICS PART B PRECERTIFICATION FORM

Cigna HealthSpring

Please fax completed form to: **1-877-730-3858** Questions? Call **1-888-454-0013**
Note: In an effort to process your request in a timely manner, please submit all pertinent clinical information.

☐ **Expedited – defined as danger to a patient's health if not provided within 72 hours**		
Patient Name		**Date of Birth**
Name of Requesting Provider		**ID Number**
Contact Person		**Date of Service**
Address		
NPI Number	**Phone Number**	**Fax Number**

If referring to a (servicing) provider, the below stated information must be submitted:	
Name of Servicing Provider	**Phone Number**
Contact Person	**Fax Number**
Address	**NPI Number**
☐ Please check if servicing provider is non-contracted/out-of-network provider/facility, please explain why:	
☐ New authorization request	☐ Extension of existing authorization. For extension of existing authorization, please submit Authorization Number:
Who will supply the medication? ☐ Provider Office ☐ Outpatient Hospital/Clinic ☐ Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes: ☐ Provider Office ☐ Outpatient Hospital/Clinic ☐ Other. Please specify:
Diagnosis Codes:	Diagnosis:

Please attach all required documentation: recent clinical notes, copy of the prescription or physician order, relevant diagnostic labs and relevant radiology notes.
All chemotherapy orders must indicate the number of cycles requested: _____ Cycles

HCPCS Codes	**Drug Name** (if applicable)	**Dose** (if applicable)	**Frequency**	**Duration**

If requesting more than 10 HCPCS codes please attach another form.

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