ARIZONA UNIFORM PRIOR AUTHORIZATION FORM

EVERNORTH℠

For Behavioral Providers

To file electronically, providers in Arizona must register for access to the online prior authorization tool:

To file via facsimile send to:
860.687.7329

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH SERVICES

CLEAR FORM

SECTION I - SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II - REASON FOR REQUEST

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☐ Initial ☐ Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III - REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

SECTION V - PROVIDER INFORMATION

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Service Care Provider's Name:	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION VI - SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version_)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Day Surgery ☐ Other _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

☐ Home Health Order Attached? ☐ Yes ☐ No Nursing Assessment Attached? ☐ Yes ☐ No

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

SECTION VII - CLINICAL DOCUMENTATION (ATTACH ADDITIONAL DOCUMENTATION AS NEEDED)

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION I - SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:

SECTION II - REASON FOR REQUEST

Check one: ☐ Initial Request ☐ Continuation/Renewal/Request

Reason for request: (check all that apply) ☐ Step Therapy, Formulary Exception ☐ Quantity Exception ☐ Specialty Drug ☐ Prior Authorization ☐ Medical Device ☐ Durable Medical Equipment (DME) ☐ Other _____

SECTION III - REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

SECTION IV - PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female	
Address:	City:		State:	Zip code:
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION V - PRESCRIBER/ORDERING PROVIDER INFORMATION

Name:	NPI #:	Specialty:		
Address:	City:		State:	Zip code:
Phone:	Fax:	Office Contact Name:		Contact Phone:

SECTION VI - PRESCRIPTION DRUG INFORMATION *(If this is a compound drug, identify all ingredients in Section VI, below.)*

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New Therapy ☐ Continuation of Therapy (approximate date therapy initiated) _____

For Provider Administered Drugs Only:

HCPCS Code: NDC #: Dose Per Administration:

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION VII - PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VIII - PRESCRIPTION DME OR MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (if applicable):

SECTION IX - PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION X - JUSTIFICATION *(Provide or attach any additional justification here: Notes, treatment plans, lab results, etc.*