Mail requests To: Cigna
8455 University Place # HQ2L-04
St. Louis, MO 63121
Fax Requests To: (886) 845-7267
Request By Phone: (877) 813-5595

Tier Exception Coverage Determination

(FOR PROVIDER USE ONLY)

MEMBER INFORMATION REQUIRED (Please Write Legibly)	
Customer Name:	Customer ID:
Customer DOB:	Customer Address:
Phone (Home):	Phone (Cell):

PROVIDER INFORMATION REQUIRED (Please Write Legibly)		
License Number:	DEA Number:	NPI Number:
Provider Name:	Provider Address:	
Provider Phone:	Provider Fax:	
Provider Specialty:	Office Contact Name:	

DRUG & PRESCRIPTION INFORMATION REQUIRED (Please Write Legibly)

Drug Name: _____ Dosage: _____

Frequency: _____ Quantity: _____ Refills: _____

☐ ***Do Not Substitute-Dispense As Written***

Please check whether this is a new medication or therapy continuation

☐ **New Medication** ☐ **Continuation**

If you have checked "Continuation",
Provide Start Date---------> _____

DIAGNOSIS INFORMATION REQUIRED (Please Write Legibly)

List Diagnosis/ICD-10 Code(s): _____

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CLINICAL INFORMATION REQUIRED (Please Write Legibly)

ATTENTION: FOR CONSIDERATION OF THE DRUG TO BE LOWERED TO A DIFFERENT COST TIER, 1) ALL THE LOWER TIER ALTERNATIVES MUST HAVE BEEN TRIED AND FAILED, or 2) THE LOWER TIER ALTERNATIVES MUST BE CLINICALLY LESS EFFECTIVE AT CONTROLLING THE MEMBER'S CONDITION OR CONTRAINDICATED FOR THE MEMBER. FAILURE TO PROVIDE CLINICAL DOCUMENTATION SUPPORTING RATIONALE MAY RESULT IN THIS REQUEST BEING DENIED, OR AN ADDITIONAL OUTREACH TO OBTAIN MISSING CLINICAL INFORMATION.

PLEASE REFER TO PATIENT'S EXPLANATION OF BENEFITS BOOKLET FOR LOWER TIER FORMULARY ALTERNATIVES. LIST ALL FORMULARY AGENTS THAT THE CUSTOMER HAS TRIED/FAILED; PLEASE INCLUDE THE DOSAGE, FREQUENCY, QUANTITY, DURATION OF THERAPY (START AND END DATES), AND OUTCOME/RATIONALE FOR NON USE :

Drug Name	Dosage	Frequency	Quantity	Start Date	End Date	Treatment Outcome/Rationale for Non Use

Other Questions:

Is this request for an inpatient that is awaiting discharge? ☐ YES ☐ NO

If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to why an exception should be made:

_____

_____

_____

☐ ***Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function***

Provider Signature: **Date:**