CIGNA
Pharmacy Management
Phone: (800)558-9363
Fax: (866)249-1172
P.O. Box 29030
Phoenix, AZ 85038-9030

CIGNA – Medicare Part D Prescription Drug Plan
- Copay Reduction Request Form -

Please Note: This form is intended for prescriber use to request a Tier Exception to reduce the copay of a non-preferred brand name medication for CIGNATURE Rx and CIGNA HealthCare for Seniors plan members. If medical necessity criteria are met and your request is approved, the copayment will be lowered to the preferred brand copayment on the plan until the end of the calendar year. Medicare Part D guidance does NOT allow tier exceptions for brand-name medications for generic copayments. Failure to complete this form in its entirety may result in 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:			* ID Number:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

Name of drug: Strength: Dosage:

Quantity prescribed per month: Expected duration of therapy:

Clinical Data:

Diagnosis related to use: *(please include ICD-9 code if available)*:

Reason for Copay Reduction/Tier Exception Request: *(please check all applicable options)*:

☐ The patient has failed or been intolerant to prior therapy with preferred brand alternative medications
Medications previously used:

☐ The patient has a contraindication to preferred brand alternative medications
Medications that are contraindicated for this patient:

Please specify the contraindication:

☐ The patient has been established and has responded to this medication
Original start date of therapy on the requested drug:

Please provide supporting details about positive response to therapy on this drug:

☐ No alternative preferred brand medications are available to treat this diagnosis
☐ Other (please specify reason):

Additional pertinent information:

Please fax completed form to (866)249-1172. Phone requests may be submitted by calling (800)558-9363.
Our standard response time for prescription drug coverage requests is 72 hours. If your request is urgent, it is important that you call CIGNA Pharmacy Management to expedite the request.

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