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

- Medication Coverage Determination Form -

Please Note: This form is intended for prescriber use to request an Exception, Prior Authorization or Step Therapy Exception for CIGNATURE Rx and CIGNA HealthCare for Seniors plan members. 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: (*please specify name, strength, route of administration and dosing schedule)*:

Diagnosis related to use:

Expected duration of therapy:

Alternative medications tried for this diagnosis: (*please include length of trial and/or if samples were given)*:

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*:

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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