



Compound Medication

Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462
 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician 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, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:

- Standard Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (please specify name, strength, and dosing schedule)

Where will this medication be obtained?

- Accredo Specialty Pharmacy**
 Prescriber's office stock (billing on a medical claim form)
 Other (please specify):
- Retail pharmacy
 Home Health / Home Infusion vendor
 **Cigna's nationally preferred specialty pharmacy

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: _____ State: _____ Tax ID#: _____
 Address (City, State, Zip Code): _____

Where will this drug be administered?

- Patient's Home Physician's Office
 Hospital Outpatient Other (please specify): _____

NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? Yes No (provide medical necessity rationale): _____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes No

Diagnosis related to use: _____ ICD10: _____

Duration of therapy: _____

Prescription Drug List alternatives tried: (please include length of trial and/or if samples were given)

Compound Ingredient Information

	Drug Name	NDC	Quantity	Cost
Ingredient #1				
Ingredient #2				

Ingredient #3				
Ingredient #4				
Ingredient #5				
Ingredient #6				
Ingredient #7				
Ingredient #8				
Ingredient #9				
Ingredient #10				

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

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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