NEW HAMPSHIRE UNIFORM PRIOR AUTHORIZATION FORM PRESCRIPTION DRUG REQUESTS

A. Destination of Request *(This section is to be completed by insurers/PBMs/UREs prior to making form available)*

Insurer or Pharmacy Benefit Manager (PBM) Name: Cigna	
Phone #: (800) 882-4462	Fax #: (855) 840-1678
Electronic Prior Authorization Webpage: https://www.covermymeds.com/main/	

Insurers and PBMs are not permitted to require information in addition to that requested below. Certain insurers may not require all of the information requested on this form.

B. Type of Request

Check one: ☐ Initial Request ☐ Continuation/Renewal Request	
Check if Expedited Review/Urgent Request: ☐	_____ **By initialing here, I, as the treating provider, attest to the fact that this request meets the URAC (Utilization Review Accreditation Commission) health accreditation standards for urgent care** in that adherence to the standard timelines: a) could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or b) would subject the patient to severe pain that cannot be adequately managed without the treatment being requested.

C. Patient Information

Patient's Full Name (including Jr, Sr, III, etc):	DOB:
Member ID #:	Group #:

D. Prescriber Information

Prescribing Provider:	Phone #:
Address:	
Secure Fax #:	Specialty:
Prescribing Provider NPI #:	Prescribing Provider DEA #:
Prescriber Point of Contact (POC) Name (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Provider or Authorized Designee Signature:	**Date**:

E. Diagnosis and Medication Information

Primary Diagnosis Related to Medication Request:	
Medication Requested:	Strength:
Quantity:	Dosing Schedule:
Length of Therapy:	Date of Prescription:
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	

 (continued on next page)

Dispense as Written (DAW) Specified? ☐ Yes ☐ No If yes, rationale for DAW:

☐ Alternate therapies contraindicated or previously tried (please provide more information in Section F)

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change (specify anticipated significant adverse clinical outcome in space below)

☐ Medical need for increase in current dosage, strength and / or frequency (specify in space below: (1) dosage, strength(s) and / or frequency(s) tried; (2) medical reason)

☐ Absence of appropriate formulation or indication of the drug (specify in space below)

☐ Other (specify in space below)

Required Explanation from Above:

F. Additional Clinical Information (provide as relevant to the request)

Drug Allergies:

Height:	Weight:

Relevant Lab Values/Test Results (Providers may attach additional pages or documentation as needed)

Lab/Test Name and Results	Date	Lab/Test Name and Results	Date

Previous Medications and/or Non-Pharmacologic Therapies Tried/Failed
(Providers may attach additional pages or documentation as needed)

Medication/Therapy Name	Strength (as relevant)	Dosing Schedule (as relevant)	Date Prescribed/ Started	Date Stopped	Description of Adverse Reaction or Failure

List any contraindications to alternate therapies (Providers may attach additional pages or documentation as needed)

Therapy	Description of Contraindication

Additional information (prescribing providers may provide additional information to support this request):

(Providers may attach additional pages or documentation as needed)

G. Confidentiality Notice

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.

Providers may attach any additional data or documentation relevant to this request.