



# 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:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> 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)					
<b>Medication requested:</b> (please specify name, strength, and dosing schedule)					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): <div style="text-align: right;"><input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **Cigna's nationally preferred specialty pharmacy</div>					
**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					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: State: Tax ID#: Address (City, State, Zip Code): <b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): <b>NOTE:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Diagnosis related to use:</b>			ICD10:		
<b>Duration of therapy:</b>					
<b>Prescription Drug List alternatives tried:</b> (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.covermymeds.com/main/prior-authorization-forms/cigna/](http://www.covermymeds.com/main/prior-authorization-forms/cigna/) or via SureScripts in your EHR.

*Most pharmacy prior authorizations are completed within two business days, unless more information is required from the provider. 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](http://cigna.com).*

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