CIGNA®

Pharmacy Services

Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Lovenox, Fragmin, Arixtra, Innohep -

Notice: Failure to complete this form in its entirety may result in delayed processing or 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:			* CIGNA ID:		
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:

☐ Dalteparin (Fragmin) ☐ Enoxaparin (Lovenox) ☐ Fondaparinux (Arixtra) ☐ Tinzaparin (Innohep)

Strength & Dose: Duration of therapy: Date of initial start of anticoagulation:

Diagnosis related to use (please specify):

☐ Deep Vein Thrombosis (DVT) ☐ Pulmonary Embolism ☐ Unstable Angina / Myocardial Infarction
☐ Atrial fibrillation ☐ Mechanical Cardiac Valve ☐ Other (*please specify*):

Medication will be used for: ☐ Prophylaxis of diagnosis ☐ Treatment of diagnosis

Is the patient pregnant? ☐ Yes ☐ No If *yes*, please specify the estimated due date:

Has the patient had failure, contraindication, or intolerance to oral anticoagulation (warfarin)? ☐ Yes ☐ No
If *yes*, please explain:

Will the patient be transitioned off the requested medication to an oral anticoagulant? ☐ Yes ☐ No
If *no*, please explain the clinical rationale why the patient will not be transitioned to an oral anticoagulant:

If *yes*, please list the date the patient is expected to become therapeutic on an oral anticoagulant:

Additional pertinent information:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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