

## CIGNA HealthCare Prior Authorization FormWeight Management Medications -

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:			respond via fax wi	**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all		
Specialty:	* DEA or TIN:		asterisked (*) item	asterisked (*) items on this form are completed**		
Office Contact Person:			* Patient Name:	* Patient Name:		
Office Phone:			* CIGNA ID:	* CIGNA ID:		
Office Fax:			* Date Of Birth:	* Date Of Birth:		
* Is your fax machine kept in a se * May we fax our response to you	* Patient Street Addr	* Patient Street Address:				
Office Street Address:			City	State	Zip	
City	State	Zip	Patient Phone:	Patient Phone:		
Medication requested (please include strength and dosing schedule):						
Patient's height:						
Patient's weight:						
Patient's Body Mass Index (BMI):						
Concomitant Risk Factors:  Please check concomitant risk factors that apply to this patient:  hypertension diabetes hyperlipidemia asthma coronary artery disease other (please specify):						
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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