MEDICARE ADVANTAGE DRUGS/BIOLOGICS PART B PRECERTIFICATION FORM

This precertification form applies to all Cigna Medicare markets except Arizona and Leon health plans. This precertification form does not apply to Medicaid only and Medicare/Medicaid Plan (MMP) plans. Please fax completed form to **1-877-730-3858**. Questions? Call **1-888-454-0013**. Note: In an effort to process your request in a timely manner, please submit all pertinent clinical information.

☐ **Expedited – defined as danger to a patient's health if not provided within 24 hours**		
Patient name:		Date of birth:
Name of requesting provider:		ID number:
Contact person:		Date of service:
Address:		
NPI number:	Phone number:	Fax number:

If referring to a (servicing) provider, the below stated information must be submitted:		
Name of servicing provider:		Phone number:
Contact person:		Fax number:
Address:		NPI number:
☐ Please check if servicing provider is non-contracted/out-of-network provider/facility, please explain why:		
☐ New authorization request	☐ Extension of existing authorization. For extension of existing authorization, please submit Authorization Number:	
Who will supply the medication? ☐ Provider office ☐ Outpatient hospital/clinic ☐ Pharmacy not located within the servicing facility	Please select place of service by checking only one of the boxes: ☐ Provider office ☐ Outpatient hospital/clinic ☐ Other. Please specify:	
Diagnosis codes:	Diagnosis:	

Please attach all required documentation: recent clinical notes, copy of the prescription or physician order, relevant diagnostic labs and relevant radiology notes.
All chemotherapy orders must indicate the number of cycles requested: ______________________________Cycles

HCPCS codes	**Drug name** (if applicable)	**Dose** (if applicable)	**Frequency**	**Duration**

If requesting more than 10 HCPCS codes please attach another form.

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