Cigna HealthSpring

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

NOFR002 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standardized Prior Authorization Request Form for Prescription Drug Benefits if the plan requires prior authorization of a prescription drug or device.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a prescription drug benefit.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:

Section I – Submission:
Enter the issuer's name and contact information. An issuer may have already entered this information on the copy of this form posted on its website.

Section VI – Prescription Compound Drug Information:
List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information:
Enter ICD Version 9 or 10, as applicable.

Section IX — Justification:
In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

SECTION I — SUBMISSION

Submitted to: Cigna-HealthSpring STAR+PLUS	Phone: 888-671-7379	Fax: 888-766-6341	Date:

SECTION II — REVIEW

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

SECTION IV — PRESCRIBER INFORMATION

Name:	NPI#:	Specialty:	
Address:	City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: _____)

For Provider Administered Drugs only:

HCPCS Code: _____ NDC#: _____ Dose Per Administration: _____

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC#	Quantity	Ingredient	NDC#	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)
