

PRESCRIPTION ADVANCE PURCHASE REQUEST FORM

Plan participants whose travel plans necessitate filling one or more prescriptions for more than a 90 day supply are required to submit a Prescription Drug Advance Purchase form to Cigna at least 5 business days in advance of the requested pharmacy pickup date. Requests for an advance purchase of less than a 90 day supply can be made by calling Cigna at 1-800-244-6224; no form is necessary.

PARTICIPANT/PATIENT INFORMATION				
Participant (Employee/Retiree) Name:		Employer: Middlebury		
Patient Name:		Cigna Account #: 3339660		
Patient Cigna ID #:		Patient Date of Birth:	Patient Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Dependent <input type="checkbox"/> Spouse	
Patient Home Phone #:	Patient Cell Phone # (Optional):	Patient Email Address (Optional):		
REASON FOR ADVANCE PURCHASE REQUEST				
Travel Reason: <input type="checkbox"/> Sabbatical <input type="checkbox"/> Study <input type="checkbox"/> Vacation <input type="checkbox"/> Other:			Dates of Travel: Depart: _____ Return: _____	
Traveling To (Location):	Requested Rx Pick-up Date:	Special Instructions:		
PRESCRIPTION INFORMATION				
Drug Name:	Strength:	Dosage:	Rx Status: <input type="checkbox"/> New <input type="checkbox"/> Refill	Prescribing Provider Name:
Drug Name:	Strength:	Dosage:	Rx Status: <input type="checkbox"/> New <input type="checkbox"/> Refill	Prescribing Provider Name:
Drug Name:	Strength:	Dosage:	Rx Status: <input type="checkbox"/> New <input type="checkbox"/> Refill	Prescribing Provider Name:
Drug Name:	Strength:	Dosage:	Rx Status: <input type="checkbox"/> New <input type="checkbox"/> Refill	Prescribing Provider Name:
PHARMACY INFORMATION				
Pharmacy Name:		Address:		Phone #:
AUTHORIZATION				
<p>I attest that the information entered on this form is correct, that I am eligible as an employee, retiree or spouse/partner or dependent for benefits under the sponsor's plan and that I need an Advance Purchase of the medication described above for the reason and period indicated. I also authorize release of information pertaining to this claim to the plan administrator or its designees as may be necessary for plan operational purposes. I understand that Cigna will contact the plan administrator for permission to advance quantities in excess of three months' supply. I understand that if my coverage is discontinued for any reason I, or the participant, will be responsible for repaying the health plan for benefits paid beyond the eligibility date.</p>				
Patient Signature			Date	

Completed forms should be faxed directly to Cigna: 860-753-4033

ADDITIONAL INFORMATION

Prescription Advance Purchases requested via this form are intended primarily for situations in which a covered individual will be unable to readily access a US pharmacy for a period of time exceeding 90 days; most typically this occurs when an individual will be spending an extended period of time abroad. Advance Purchase authorizations may also be appropriate for individuals remaining in the US who will be spending extended periods of time in a location without ready access to a pharmacy (for example extended fieldwork conducted in a remote location.)

Individuals who need less than a 90 day medication advance do not need to submit the Prescription Advance Purchase Request form. Instead, the employee, retiree, dependent or pharmacist can call Cigna customer service at 800-244-6224 to request the advance.

Participants who will be temporarily relocating within the US (for example, dependents studying out-of-state, retirees wintering in warmer climes, sabbaticals spent at other US institutions, etc.) generally should transfer their prescriptions to a pharmacy in the new location. However a short-term transitional override can be requested by calling Cigna at 800-244-6224.