

CIGNA Specialty Pharmacy Services Erbitux® Fax Order Form



Please deliver by: _____

Requests received after 4 p.m. CT will begin processing the following business day.

Fax: 1.800.351.3616
Phone: 1.800.351.3606

Order #: _____ Referral Source Code: 652

PATIENT INFORMATION (Please Print)			PHYSICIAN INFORMATION	
PATIENT NAME:	DATE OF BIRTH :	NAME:	DEA #:	NPI:
HEALTH CARE ID #:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
HOME PHONE:				
WORK PHONE:	ALT PHONE:	TELEPHONE:	FAX:	
ADDRESS: (Street) (City) (State) (Zip Code)		Medications shipped to MD office unless otherwise specified <input type="checkbox"/> Other Shipping address:		
ALLERGIES: <small>If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Specialty Pharmacy previously.</small>		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes		
PATIENTS HEIGHT:	PATIENTS WEIGHT:	LOCAL HOME HEALTH AGENCY:	TELEPHONE:	

PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH	DOSE AND DIRECTIONS	NUMBER OF DOSES	REFILLS
ERBITUX® (cetuximab)				

ZOFRAN TABLET: <input type="checkbox"/> 4mg Tablets <input type="checkbox"/> 4mg Orally Disintegrating Tablets <input type="checkbox"/> 8mg Tablets <input type="checkbox"/> 8mg Orally Disintegrating Tablets	DIRECTIONS: QTY: _____ REFILLS: _____
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PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:

Physician's PRINTED NAME:	DATE:
Physician's SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)	
In order for a brand name product to be dispensed, the prescriber must handwrite " Brand Necessary " or " Brand Medically Necessary " on the prescription	

CLINICAL INFORMATION

Is this a new start? Yes No Start date:

Frequency of therapy: Length of therapy:

What is the patient's current height? What is the patient's current weight?

Will this medication be given concurrently with other agents? Yes No If yes, please specify:

Is the patient a candidate for home infusion? Yes No

Does the provider have an in-office infusion site? Yes No

What is the patient's diagnosis?

- Head/Neck Cancer Non-Small Cell Lung Cancer (NSCLC) Small Bowel Adenocarcinoma
 Menetrier's Disease Colorectal Cancer Other (please specify):

For head/neck cancer does the patient have squamous cell carcinoma? Yes No

For head/neck cancer is Erbitux being given with radiation? Yes No

For NSCLC does the patient have metastatic or recurrent non-small cell lung cancer? Yes No

For colorectal cancer does the patient have advanced or metastatic disease? Yes No

For colorectal cancer does the patient have wild-type KRAS (Kirsten rat sarcoma) gene? Yes No

For small bowel adenocarcinoma does the patient have advanced or metastatic disease? Yes No

For small bowel adenocarcinoma does the patient have wild-type KRAS (Kirsten rat sarcoma) gene? Yes No