

CIGNA Specialty Pharmacy Services Herceptin® 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		
PATIENT HEIGHT	PATIENT WEIGHT	LOCAL HOME HEALTH AGENCY:	TELEPHONE:	

PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH	DOSE AND DIRECTIONS	NUMBER OF DOSES	REFILLS
HERCEPTIN® (trastuzumab)				

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 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?

Breast Cancer Gastric Cancer Gastroesophageal Junction Adenocarcinoma Other (please specify):

For breast cancer:

Is this treatment for HER2 positive breast cancer? Yes No

Is this for adjuvant therapy or treatment of metastatic disease? Yes No

For gastric cancer or gastroesophageal junction adenocarcinoma:

Is this treatment of HER2 positive cancer? Yes No

Is this being used as first line therapy for metastatic disease? Yes No

Additional pertinent information: