

Cigna Specialty Pharmacy Services – Hizentra Fax Order Form

Please deliver by: _____

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



Phone: 1.800.351.3606 ext. 273-0049

Fax: 1.800.351.3616

Order #: _____ Referral Source Code: **652**

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:	DATE OF BIRTH :	NAME:	
HEALTH CARE ID #:	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	DEA #:	NPI:
HOME PHONE:	ALT PHONE:	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	TELEPHONE:
ADDRESS: (Street) (City) (State) (Zip Code)		TELEPHONE:	FAX:
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	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:
		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home <small>Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.</small>	
*Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No		*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PRESCRIPTION INFORMATION			
* HIZENTRA 20% <input type="checkbox"/> Infuse _____ grams SQ one time per week <input type="checkbox"/> Other (please specify):		QTY/REFILLS <input type="checkbox"/> 1 month supply _____ refills <input type="checkbox"/> 3 month supply _____ refills <input type="checkbox"/> Other: _____ QTY _____ refills	
If needing products requiring a prescription, such as Emla or Normal Saline, please provide prescriptions here:			
<input type="checkbox"/> EMLA QTY : One 30 GM tube DIRECTIONS: Apply as directed REFILLS: 1 year		<input type="checkbox"/> Other (please specify): QTY : DIRECTIONS: REFILLS:	
PUMP FOR SUBCUTANEOUS INFUSION Will patient need to have a Freedom 60 pump supplied by Cigna Specialty Pharmacy Services? Yes <input type="checkbox"/> No <input type="checkbox"/> *Freedom 60 is the only pump Cigna Specialty Pharmacy Services supplies. Please see next page for supply needs.			
PHYSICIAN'S PRINTED NAME:		DATE:	
PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)			

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
PRESCRIPTION INFORMATION (Continued)		
SELECT A TUBING SET FOR THE FREEDOM 60 PUMP: <input type="checkbox"/> F275 -- 275ml/hr rate set <input type="checkbox"/> F600 --600ml/hr rate set <input type="checkbox"/> F900 --900ml/hr rate set <input type="checkbox"/> F1200 -- 1200ml/hr rate set <input type="checkbox"/> F2400 -- 2400ml/hr rate set <input type="checkbox"/> Other (please specify):	SELECT A SQ NEEDLE SET: (Please specify mfg) Mfg: <input type="checkbox"/> Emend <input type="checkbox"/> Marcal <input type="checkbox"/> Other (please specify): (Please indicate # of sites) Number of sites: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other (please specify): (Please indicate a gage) Gage: <input type="checkbox"/> 27 <input type="checkbox"/> Other (please specify): (Please indicate length) Needle length: <input type="checkbox"/> 6mm <input type="checkbox"/> 9mm <input type="checkbox"/> 12mm <input type="checkbox"/> Other (please specify):	
OTHER SUPPLIES: 60ml syringes will be automatically supplied Use to withdraw Hizentra from vials <input type="checkbox"/> Mini-spike <input type="checkbox"/> 16g 1" needle <input type="checkbox"/> 18g 1" needle Other non-prescription supplies will be filled as requested by patient.		
Please specify the diagnosis and ICD-9 code:		
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		

***CIGNA Preferred Status:**

- It is the decision of the prescribing physician in the exercise of his/her independent clinical judgment to determine which medication to prescribe. Coverage is not limited to the preferred drug.
- CIGNA HealthCare may receive payments from manufacturers whose medications are included on the Preferred Specialty (Injectable) Drug List. These payments may or may not be shared with the member's benefit plan dependent on the contractual arrangement between the plan and CIGNA.
- Depending upon plan design, market conditions, the extent to which manufacturers' payments are shared with the member's benefit plan, and other factors as of the date of service, the preferred medication may or may not represent the lowest cost medication within the therapeutic class for the member and/or the benefit plan.
- CIGNA HealthCare reserves the right to make changes to its Preferred Specialty (Injectable) Drug List without notice.

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