

CIGNA Specialty Pharmacy Services Blood Modifier 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:		TELEPHONE:			FAX:
WORK PHONE:	ALT PHONE:		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home		
ADDRESS: (Street) (City) (State) (Zip Code)		Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.			
ALLERGIES:		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes			TELEPHONE:
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.		LOCAL HOME HEALTH AGENCY:			

PRESCRIPTION INFORMATION			
PROCIT® VIALS <input type="checkbox"/> 2,000 units/1 ml <input type="checkbox"/> 3,000 units/1 ml <input type="checkbox"/> 4,000 units/1 ml <input type="checkbox"/> 10,000 units/1 ml		EPOGEN® VIALS <input type="checkbox"/> 2,000 units/1 ml <input type="checkbox"/> 3,000 units/1 ml <input type="checkbox"/> 4,000 units/1 ml <input type="checkbox"/> 10,000 units/1 ml	
<input type="checkbox"/> 20,000 units/1 ml (multi-dose vial) <input type="checkbox"/> 20,000 units/2 ml (10,000 units/1 ml multi-dose vial) <input type="checkbox"/> 40,000 units/1 ml		<input type="checkbox"/> 20,000 units/1 ml (multi-dose vial) <input type="checkbox"/> 20,000 units/2 ml (10,000 units/1 ml multi-dose vial)	

ARANESP® (Please select Vials, or Prefilled Syringe)			
Vials		Prefilled Syringes	
<input type="checkbox"/> 25 mcg/1 ml	<input type="checkbox"/> 150 mcg/0.75 ml	<input type="checkbox"/> 25 mcg/0.42 ml	<input type="checkbox"/> 150 mcg/0.3 ml
<input type="checkbox"/> 40 mcg/1 ml	<input type="checkbox"/> 200 mcg/1 ml	<input type="checkbox"/> 40 mcg/0.4 ml	<input type="checkbox"/> 200 mcg/0.4 ml
<input type="checkbox"/> 60 mcg/1 ml	<input type="checkbox"/> 300 mcg/1 ml	<input type="checkbox"/> 60 mcg/0.3 ml	<input type="checkbox"/> 300 mcg/0.6 ml
<input type="checkbox"/> 100 mcg/1 ml		<input type="checkbox"/> 100 mcg/0.5 ml	<input type="checkbox"/> 500 mcg/1 ml

*DOSE and DIRECTIONS:	QTY:
*Please provide dose & directions	REFILLS:

SUPPLIES NEEDED (if medication is to be administered in patient's home): If checked, please specify the size and type (if applicable):

Syringes/Needles Swabs Sharps Container Other

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

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

