

CIGNA Specialty Pharmacy Services Plaque Psoriasis 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 : | |
| HEALTH CARE ID #: | | SEX: <input type="checkbox"/> M <input type="checkbox"/> F | |
| HOME PHONE: | | ADDRESS: (Street/Suite #) (City) (State) (Zip Code) | |
| WORK PHONE: | ALT PHONE: | TELEPHONE: | FAX: |
| ADDRESS: (Street) (City) (State) (Zip Code) | | SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery. | |
| 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: |
| PRESCRIPTION INFORMATION | | | |
| * ENBREL® (Etanercept - J1438): Please see www.cigna.com for a Enbrel order form or contact Specialty Pharmacy at the phone number listed above | | | |
| * HUMIRA® (Adalimumab – J0135): Please see www.cigna.com for a Humira order form or contact Specialty Pharmacy at the phone number listed above | | | |
| REMICADE® (Infliximab - J1745) Please see www.cigna.com for a Remicade order form or contact Specialty Pharmacy at the phone number listed above. | | | |
| STELARA® 45mg/0.5ml Prefilled Syringe (ustekinumab – J3590) (Recommended dose for people weighing ≤100 kg (220 lbs) is 45mg) Patient's weight _____ lb _____ kg | | DIRECTIONS: Starter Dose: <input type="checkbox"/> Inject 45mg SC initially and 4 weeks later <input type="checkbox"/> Other: Maintenance Dose: <input type="checkbox"/> Inject 45mg SC every 12 weeks: <input type="checkbox"/> Other: | |
| | | QTY <input type="checkbox"/> Dispense starter dose 1 and 2 <input type="checkbox"/> Other: _____ QTY _____ refills QTY <input type="checkbox"/> 1 dose _____ refills <input type="checkbox"/> Other: _____ QTY _____ refills | |
| PHYSICIAN'S PRINTED NAME: | | DATE: | |
| PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information) | | | |

***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.

| | | |
|--|---|---|
| PATIENT NAME: | HEALTH CARE ID #: | DATE OF BIRTH: |
| STELARA® 90mg/ml Prefilled Syringe (ustekinumab – J3590) (Recommended dose for people weighing >100 kg (220 lbs) is 90mg) Patient's weight _____lb _____kg | Starter Dose: <input type="checkbox"/> Inject 90mg SC initially and 4 weeks later <input type="checkbox"/> Other | QTY <input type="checkbox"/> Dispense starter dose 1 and 2 <input type="checkbox"/> Other: _____ QTY _____ refills |
| | Maintenance Dose: <input type="checkbox"/> Inject 90mg SC every 12 weeks: <input type="checkbox"/> Other: | QTY <input type="checkbox"/> 1 dose _____ refills <input type="checkbox"/> Other: _____ QTY _____ refills |
| ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT: | | |
| SUPPLIES NEEDED (if medication is to be administered in patient's home): If checked, please specify the size and type (if applicable): <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <input type="checkbox"/> Other | | |
| 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 | | |
| Answer the following questions on requests for Stelara. | | |
| Diagnosis related to use: <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Other (please specify): | | |
| Clinical Information: What is the patient's current weight? Does the patient have a history of a beneficial clinical response to ustekinumab (Stelara) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient ever been treated with phototherapy or systemic therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient a candidate for phototherapy or systemic therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists? <input type="checkbox"/> *Humira <input type="checkbox"/> *Enbrel Additional pertinent information: | | |

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