

CIGNA Specialty Pharmacy Services Enbrel® Fax Order Form



Please deliver by: _____

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

Order #: _____ Referral Source Code: 652

Fax: 1.800.351.3616

Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:	DATE OF BIRTH :	NAME:	
HEALTH CARE ID #:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	DEA #:	NPI:
HOME PHONE: <small>Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.</small>	ALT PHONE:	TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		* 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	
		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
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 Services previously.</small>		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home	
		<small>If "Physician's Office" is selected please indicate if you can only accept delivery on specific days</small>	

PRESCRIPTION INFORMATION

* ENBREL® 25mg(Etanercept - J1438): <input type="checkbox"/> 25 mg/ml Vial <input type="checkbox"/> 25 mg/0.5ml Prefilled Syringe	DIRECTIONS: <input type="checkbox"/> Inject 25 mg SC two times per week <input type="checkbox"/> Inject 25mg SC one time a week <input type="checkbox"/> Other:	QTY/REFILLS: <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____QTY ____ refills **3 month supplies of medications can result in lower copays for the member**
	STARTER DOSE: <input type="checkbox"/> Inject 50mg SC two times per week for 3 months, then inject 50mg SC one time per week thereafter.	QTY/REFILLS: <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____QTY ____ refills **3 month supplies of medications can result in lower copays for the member**
* ENBREL® 50mg (Etanercept - J1438): <input type="checkbox"/> 50 mg/ml Prefilled Syringe <input type="checkbox"/> 50 mg/ml SureClick™ Autoinjector <input type="checkbox"/> Pharmacy asks patient for preference	MAINTENANCE DOSE: <input type="checkbox"/> Inject 50 mg SC one time per week <input type="checkbox"/> Inject 50 mg SC two times per week <input type="checkbox"/> Other:	QTY/REFILLS: <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____QTY ____ refills **3 month supplies of medications can result in lower copays for the member**

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

Physician's PRINTED NAME: _____ DATE: _____

Physician's SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

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

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**" on the prescription

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
PRESCRIPTION INFORMATION (Continued)		
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:		
MARK THE DIAGNOSIS:		
<input type="checkbox"/> Rheumatoid Arthritis = 714.0 (ICD-9)	<input type="checkbox"/> Psoriatic Arthritis = 696.0 (ICD-9)	<input type="checkbox"/> Polyarticular Juvenile Arthritis = 714.30 (ICD-9)
<input type="checkbox"/> Ankylosing Spondylitis = 720.0 (ICD-9)	<input type="checkbox"/> Reactive Arthritis = _____ (ICD-9)	<input type="checkbox"/> Chronic Plaque Psoriasis = 696.1 (ICD-9)
<input type="checkbox"/> Inflammatory Bowel Disease Arthritis = _____ (ICD-9) <input type="checkbox"/> Other (please specify diagnosis and ICD-9 code): _____		
Rheumatoid Arthritis or Juvenile Rheumatoid Arthritis:		
Does the patient have a history of positive clinical response to Enbrel (etanercept) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following disease-modifying anti-rheumatic drugs (DMARDs). Please check all that apply:		
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Azathioprine	<input type="checkbox"/> Gold
<input type="checkbox"/> Penicillamine	<input type="checkbox"/> Sulfasalazine	<input type="checkbox"/> Hydroxychloroquine
<input type="checkbox"/> Other (please specify): _____		
Chronic Plaque Psoriasis:		
Does the patient have a history of positive clinical response to Enbrel (etanercept) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the severity great enough that the patient is a candidate for Photo or Systemic therapy or have they received either in the past?		
<input type="checkbox"/> Yes Please explain:		
<input type="checkbox"/> No Please explain:		
Psoriatic Arthritis or Reactive Arthritis:		
Does the patient have a history of positive clinical response to etanercept therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Inflammatory Bowel Disease Arthritis:		
Does the patient have a history of positive clinical response to etanercept therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have evidence of failure, intolerance or contraindication to sulfasalazine, azathioprine, steroids or methotrexate therapy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ankylosing Spondylitis:		
Does the patient have a history of positive clinical response to etanercept therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have evidence of failure, intolerance or contraindication to non-steroidal anti-inflammatory drugs (NSAIDs) therapy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Pertinent Information:		
Please fax completed form to (800) 351.3616. Phone requests may be submitted by calling (800) 351.3606.		

***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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