CIGNA Specialty Pharmacy Services Neutropenia Fax Order Form

Please deliver by: ________________

Requests received after 4 p.m. CST 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:	
HEALTH CARE ID #:	SEX: ☐ M ☐ F	DEA:	NPI:
HOME PHONE:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
WORK PHONE:	ALT PHONE:	TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		**SHIP MEDICATIONS TO:** ☐ Physician's Office ☐ Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery. *Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No	
ALLERGIES: 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.		**HOME HEALTH SERVICES REQUIRED?** ☐ No ☐ Yes LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION

NEULASTA® (Pegfilgrastim - J2505)
- ☐ 6 mg/0.6 ml prefilled syringe

NEUPOGEN® (Filgrastim - J1440)
- ☐ 300 mcg/1 ml vial
- ☐ 480 mcg/1.6 ml vial
- ☐ 300 mcg/0.5 ml prefilled syringe
- ☐ 480 mcg/0.8 ml prefilled syringe

LEUKINE® (Sargramostim – J2820)
- ☐ 250mcg power vial
- ☐ 500mcg/ml liquid vial

Send 1ml diluent per vial for reconstitution prior to administration choose one : ☐ Sterile water OR ☐ Bacteriostatic water

DOSE and DIRECTIONS:	QTY:	REFILLS:

Route of administration:
- ☐ Sub-cutaneous
- ☐ Infused via implanted pump
- ☐ Infused via external pump
- ☐ I.V. infused
- ☐ Intramuscular
- ☐ Other (*please specify*):

Where will this drug be administered?
- ☐ Patient's Home
- ☐ Provider's Office
- ☐ Other (*please specify*):

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

SUPPLIES NEEDED *(if medication is to be administered in patient's home)*:
☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other

If checked, please specify the size and type (if applicable):

Primary Prophylaxis of Febrile Neutropenia:

Is the patient receiving myelosuppressive chemotherapy? Yes ☐ No ☐

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If *yes*, what is the patient's FN rate?

Is the patient receiving non-myelosuppressive chemotherapy? Yes ☐ No ☐
If *yes*, is the patient at increased risk for febrile neutropenia? Yes ☐ No ☐

If *yes*, please specify:

Secondary Prophylaxis of Febrile Neutropenia:

Is there documentation of febrile neutropenia from a prior cycle of chemotherapy for which primary prophylaxis was not received? Yes ☐ No ☐

Is chemotherapy dose reduction a viable option as an alternative means of preventing febrile neutropenia?
Yes ☐ No ☐

Is prolonged neutropenia creating a delay in chemotherapy treatment? Yes ☐ No ☐

Treatment of Febrile Neutropenia:

Please select any of the following indications the patient has (check all that apply).

☐ Expected prolonged (greater than 10 days) and profound (absolute neutrophil count less than .1 x 109/L) neutropenia.
☐ Hypotension
☐ Multi-organ dysfunction (sepsis syndrome)
☐ Uncontrolled primary disease
☐ Invasive fungal infection
☐ Pneumonia
☐ Development of fever while hospitalized

Patients with Acute Myeloid Leukemia (AML):

Is the patient receiving induction chemotherapy? Yes ☐ No ☐

Patients with Acute Lymphoblastic Leukemia (ALL):

Is Neulasta/Neupogen being administered after completion of the first few days of chemotherapy of the initial induction or first post-remission course? Yes ☐ No ☐

Patients with Myelodysplastic Syndromes:

Is Neulasta/Neupogen being administered intermittently and the patient is experiencing severe neutropenia (absolute neutrophil count (ANC) of less than 500 per microlitter (µL)) or recurrent infections? Yes ☐ No ☐

All other uses:

Diagnosis:

Other pertinent information:

ADDITIONAL PERTINENT INFORMATION:

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

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