

**CIGNA Specialty Pharmacy Services**  
**Fuzeon® 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	
*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	
LOCAL HOME HEALTH AGENCY:		TELEPHONE:	

**PRESCRIPTION INFORMATION**

**FUZEON® 90 mg/cc** (Enfuvirtide - J3490)

Adult DIRECTIONS: **Inject 1cc SC BID** QTY (# of 30-day kits): \_\_\_\_\_ REFILLS: \_\_\_\_\_

Pediatrics DIRECTIONS: **Calculated \_\_\_\_\_ cc SC BID** QTY (# of 30-day kits): \_\_\_\_\_ REFILLS: \_\_\_\_\_  
 (weight-based dosing - refer to product information)  
 Weight: \_\_\_\_\_ kg OR \_\_\_\_\_ lb

DOES THE PATIENT REQUIRE A PATIENT STARTER KIT:  Yes  No

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

**MARK THE DIAGNOSIS:**

Human immunodeficiency virus (HIV) Infection = 042 (ICD-9)  Other (List Diagnosis ICD-9): \_\_\_\_\_

**Clinical Information:**

Has this patient been treated with other antiretroviral agents?  Yes  No

If YES, please list previous ARV medications and length of treatment:

Does this patient have evidence of HIV-1 replication despite ongoing antiretroviral therapy?  Yes  No

Will Fuzeon be used in combination with other antiretroviral agents?  Yes  No

Additional pertinent information:

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