CIGNA Specialty Pharmacy Services Hemophilia Injectable 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:	DEA:	NPI:
HEALTH CARE ID #:		GENDER: ☐ M ☐ F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
HOME PHONE:	ALT PHONE:		TELEPHONE:	FAX:	
ADDRESS: (Street) (City) (State) (Zip Code)			*Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No		
			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.		
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

☐ **ADVATE®** (Antihemophilic Factor – J7192)	☐ **KOGENATE FS®** (Antihemophilic Factor – J7192)
☐ **ALPHANINE® (**Coagulation Factor IX – J7193)	☐ **MONOCLATE-P®** (Antihemophilic Factor – J7190)
☐ **ALPHANATE® (**Antihemophilic Factor – J7186)	☐ **MONONINE®** (Coagulation Factor IX – J7193)
☐ **BEBULIN VH® (**Coagulation Factor IX – J7194)	☐ **NOVOSEVEN RT®** (Coagulation Factor VIIA – J7189)
☐ **BENEFIX®** (Coagulation Factor IX – J7195)	☐ **PROFILNINE®** (Coagulation Factor IX – J7194)
☐ **FEIBA®** (Antiinhibitor Coagulant – J7198)	☐ **RECOMBINATE®** (Antihemophilic Factor – J7192)
☐ **HELIXATE FS®** (Antihemophilic Factor – J7192)	☐ **WILATE®** (Coagulation Factor VIII – J7188)
☐ **HEMOFIL M®** (Antihemophilic Factor – J7190)	☐ **XYNTHA®** (Antihemophilic Factor – J3490)
☐ **HUMATE-P®** (Antihemophilic Factor – J7187)	☐ **OTHER** (please specify drug name and J-Code):
☐ **KOATE DVI®** (Antihemophilic Factor – J7190)	

Provide dosing. If dosing provided in units/kg only, please provide the patient's weight: ______ lb **OR** ______ kg

PROPHYLACTIC DOSING (Please specify dose in units, vWF: RCop or mg)

Dispense appropriate number of doses for a 30 day supply ☐ **OR** Dispense this number of doses for 30 day supply ______ REFILLS: _____

EPISODIC DOSING (Please specify dose in units, vWF: RCop or mg)

*Number of Doses needed for a 30 day supply:_______ REFILLS: ______

* If prescription indicates different dosing for different bleeds, please make sure indicate the number of doses that should be dispensed for each type of bleed.

Based on bleeding history, patient to maintain this many doses onhand ______ IV Access: ☐ PIV/Butterfly ☐ PICC ☐ Port ☐Central Line

PLEASE INDICATE ANY ADDITIONAL MEDICATIONS AND SUPPLIES:

☐ **Heparin** ______ units/ml ☐ Vial ☐ Prefilled Syringe _____ml per flush ______ number of flushes needed per infusion

☐ **Normal Saline** ☐ Vial ☐ Prefilled Syringe ______________ ml per flush _____________ number of flushes needed per infusion

***Refills will be the same as the factor medication.**

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

MARK THE DIAGNOSIS: ☐ Congenital Factor VIII Disorder = 286.0 (ICD-9) ☐ Other *(List Diagnosis and ICD-9)*: ______

Formulary alternatives tried:

Clinical Information:

What past conventional therapies (if any) has the patient tried?

ADDITIONAL PERTINENT INFORMATION:

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