

CIGNA Specialty Pharmacy Services High Risk Maternity Fax Order Form



Please deliver by: _____

Requests received after 1 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:	NAME:
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	DEA #:
HOME PHONE:		ALT PHONE:	NPI:
ADDRESS: (Street) (City) (State) (Zip Code)		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
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.		TELEPHONE:	
*Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No		FAX:	
*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.	
HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
LOCAL HOME HEALTH AGENCY		TELEPHONE:	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> MAKENA® 250mg/ml 5ml Multiple Dose Vial		DIRECTIONS: <input type="checkbox"/> Inject 250mg (1ml) IM QW <input type="checkbox"/> Other (please specify): _____	QTY/ REFILLS <input type="checkbox"/> 5 WEEK SUPPLY (Only dispensed in 5 week supply) REFILLS: _____
<input type="checkbox"/> COMPOUNDED 17P: Hydroxyprogesterone Caproate in <u>Sesame Oil</u> compound (250mg/ml in 4ml Multiple Dose Vials)		DIRECTIONS: <input type="checkbox"/> Inject 250mg (1ml) IM QW <input type="checkbox"/> Other (please specify): _____	QTY/ REFILLS <input type="checkbox"/> 1 MONTH SUPPLY (Only dispensed in 1 month supply) REFILLS: _____
<input type="checkbox"/> COMPOUNDED 17P: Hydroxyprogesterone Caproate in <u>Castor Oil</u> compound (250mg/ml in 2ml Multiple Dose Vials)		DIRECTIONS: <input type="checkbox"/> Inject 250mg (1ml) IM QW <input type="checkbox"/> Other (please specify): _____	QTY/ REFILLS <input type="checkbox"/> 1 MONTH SUPPLY (Only dispensed in 1 month supply) REFILLS: _____
ZOFRAN TABLET: <input type="checkbox"/> 4mg Tablets <input type="checkbox"/> 4mg Orally Disintegrating Tablets <input type="checkbox"/> 8mg Tablets <input type="checkbox"/> 8mg Orally Disintegrating Tablets		DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PRE-NATAL VITAMINS: Drug Name: _____ Strength: _____ (If specific prenatal brand not indicated, we will fill with our preferred brand - Prenatal Plus Tablet)		DIRECTIONS:	QTY/ REFILLS <input type="checkbox"/> 3 MONTH SUPPLY <input type="checkbox"/> OTHER QTY _____ REFILLS: _____
Physician's PRINTED NAME:		DATE:	
Physician's SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)			

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
SUPPLIES NEEDED (if medication is to be administered in patient's home): <input type="checkbox"/> Syringes/Needles <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <input type="checkbox"/> Other		If checked, please specify the size and type (if applicable):
ZOFRAN CLINICAL INFORMATION		
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:		
Clinical Data:		
Will this medication be used for treatment or prevention of nausea/vomiting?: <input type="checkbox"/> Treatment <input type="checkbox"/> Prevention <input type="checkbox"/> Both What is the patient's diagnosis? <input type="checkbox"/> Pregnancy-related Nausea and vomiting (morning sickness/hyper-emesis) <input type="checkbox"/> Other (please specify): If not specified above, what is the cause of the nausea and/or vomiting? (please specify): Which first-line medications (such as metoclopramide, corticosteroids, antihistamines, butyrophenones or phenothizines) has the patient tried? Please include medication name, dosing schedule and outcome of therapy: Does the patient have a contraindication to the first-line medications listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No Additional pertinent information:		

MAKENA CLINICAL INFORMATION
Clinical Data:
Is Makena being used to reduce the risk of recurrent preterm birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Gestational age at time of previous preterm birth: ____ weeks and ____ days Was the previous preterm birth spontaneous: <input type="checkbox"/> Yes <input type="checkbox"/> No Was the previous preterm birth a Singleton Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Current gestational age: ____ weeks and ____ days Is the current pregnancy a Singleton Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Date at which patient will be 36 weeks and 6 days gestation: _____
In order for a brand name product to be dispensed, the prescriber must handwrite " Brand Necessary " or " Brand Medically Necessary " on the prescription