



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: ALT PHONE:		TELEPHONE: FAX:	
Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.			
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: 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.		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home If "Physician's Office" is selected please indicate if you can only accept delivery on specific days	

PRESCRIPTION INFORMATION		
* HUMIRA® 40mg/0.8ml (Adalimumab - J0135) Crohn's Disease Starter Pack Self-Injectable Pen	DIRECTIONS: <input type="checkbox"/> Inject four 40mg pens (all on one day) SC initially and then inject two 40mg pens 2 weeks later <input type="checkbox"/> Inject four 40mg pens (2 pens per day for 2 consecutive days) SC initially and then inject two 40mg pens 2 weeks later <input type="checkbox"/> Other:	QTY: 6 pens REFILLS: 0
* HUMIRA® 40mg/0.8ml (Adalimumab - J0135) Psoriasis Starter Pack Self-Injectable Pen	DIRECTIONS: <input type="checkbox"/> Inject two 40mg pens SC for first dose (Day 1), then inject one 40mg pen SC one week after first dose (Day 8), then inject one 40mg pen SC three weeks after first dose (Day 22), then inject one 40mg pen SC every other week. <input type="checkbox"/> Other:	QTY: 4 pens REFILLS: 0
* HUMIRA® 40 mg/0.8ml (Adalimumab - J0135) <input type="checkbox"/> Self-Injectable Pen <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Pharmacy ask patient for preference	DIRECTIONS: <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every 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**
* HUMIRA® 20mg/0.4ml (Adalimumab - J0135) Prefilled Syringe (Typically used for people weighing 33-66lbs with the diagnosis of Juvenile Idiopathic Arthritis)	DIRECTIONS: <input type="checkbox"/> Inject 20mg SC every other 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**

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): Sharps Container Other:

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

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

Diagnosis Code (ICD-9): _____			
Please indicate the condition Humira is being used to treat and answer additional questions as necessary. You may include applicable chart notes with this form.			
<input type="checkbox"/>	Ankylosing Spondylitis Additional Question(s)	Does patient have a history of positive clinical response to *Humira (adalimumab)?	Answer/Detail:
		Does patient have evidence of failure, intolerance or contraindication to Non-Steroidal Anti-Inflammatory (NSAID) medications?	Answer/Detail:
<input type="checkbox"/>	Psoriatic Arthritis Additional Question(s)	Does patient have a history of positive clinical response to *Humira (adalimumab)?	Answer/Detail:
		Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy?	Answer/Detail:
<input type="checkbox"/>	Active Crohn's Disease Additional Question(s)	Does patient have a history of positive clinical response to *Humira (adalimumab)?	Answer/Detail:
		Does patient have evidence of failure, intolerance or contraindication, or inadequate response to conventional therapies (such as aminosalicylate, corticosteroids or immunomodulators)?	Answer/Detail:
<input type="checkbox"/>	Rheumatoid Arthritis or Juvenile Idiopathic Arthritis		
	What is the patient's diagnosis? <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Juvenile Idiopathic Arthritis		
	What is the patient's current weight?		
	Does the patient have a history of beneficial clinical response to *Humira 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"/> Hydroxychloroquine <input type="checkbox"/> Penicillamine <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other (please specify):		
<input type="checkbox"/>	Chronic Plaque Psoriasis		
	Does patient have a history of positive clinical response to *Humira (adalimumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is the patient a candidate for, or have they previously received, systemic therapy (Methotrexate, cyclosporin, soriatane)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the patient a candidate for, or have they previously received, phototherapy (Narrow and Broad Band UVB, PUVA)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/>	Other (please specify diagnosis and any additional applicable information)		

***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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