



CIGNA Specialty Pharmacy Services - Joint Degeneration 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

Order #: _____ Referral Source Code: 652

Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:		DATE OF BIRTH :	
HEALTH CARE ID #:		NAME:	
GENDER: <input type="checkbox"/> M <input type="checkbox"/> F		DEA #:	NPI:
HOME PHONE:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
ALT PHONE:		TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		*Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ALLERGIES:		*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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.		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.	
		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION	
<input type="checkbox"/> EUFLEXXA® (Sodium Hyaluronate – J7323) 10 mg/ml (2 ml) Prefilled Syringe	WEEKLY DOSING FOR 3 WEEKS: (Pharmacy will send quantity sufficient for directions provided.) <input type="checkbox"/> Inject one prefilled syringe as directed every week for 3 weeks <input type="checkbox"/> Inject one prefilled syringe to each knee as directed every week for three weeks Refills: _____
<input type="checkbox"/> SUPARTZ® (Sodium Hyaluronate – J7321) 10 mg/ml (2.5 ml) Prefilled Syringe	WEEKLY DOSING FOR 5 WEEKS: (Pharmacy will send quantity sufficient for directions provided.) <input type="checkbox"/> Inject one prefilled syringe as directed every week for 5 weeks <input type="checkbox"/> Inject one prefilled syringe to each knee as directed every week for five weeks Refills: _____
<input type="checkbox"/> SYNVISCO® (Hylan – J7322) (Typically administered in a series of 3 injections) 8 mg/ml (2 ml) Prefilled Syringe	<input type="checkbox"/> Other: _____ Quantity: _____ Refills: _____
<input type="checkbox"/> ORTHOVISC® (Sodium Hyaluronate – J7324) 15 mg/ml (2 ml) Prefilled Syringe	
<input type="checkbox"/> HYALGAN® (Sodium Hyaluronate – J7321) 10 mg/ml (2 ml) Prefilled Syringe	
<input type="checkbox"/> SYNVISCO-ONE® (Hylan – J7325) (6ml single injection) 8 mg/ml (6 ml) Prefilled Syringe	<input type="checkbox"/> Inject the prefilled syringe one time as directed <input type="checkbox"/> Inject one prefilled syringe to each knee one time as directed Refills: _____

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

PHYSICIAN'S PRINTED NAME: _____ DATE: _____

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

PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:

MARK THE DIAGNOSIS: Degenerative Joint Disease = 715.9 (ICD-9) Other (List Diagnosis ICD-9): _____

DOES THE PATIENT HAVE PAINFUL OSTEOARTHRITIS OF THE KNEE? Yes No

WHICH PRIOR ANALGESIC MEDICATIONS (INCLUDING ACETAMINOPHEN, NSAIDS AND COX-II INHIBITORS) HAS THE PATIENT TRIED? PLEASE PROVIDE THE MEDICATION NAME, DOSE, DATES OF USE, AND PLEASE NOTE ANY ADVERSE EFFECTS OF MEDICATIONS.

DOES THE PATIENT HAVE A CONTRAINDICATION TO ANALGESICS (SUCH AS ACETAMINOPHEN, NSAIDS AND COX-II INHIBITORS)?
 No Yes IF YES, PLEASE SPECIFY THE CONTRAINDICATION:

PLEASE NOTE ANY CONSERVATIVE NON-PHARMACOLOGIC THERAPIES TRIED (FOR EXAMPLE, PHYSICAL THERAPY, ETC.):

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