

CIGNA Specialty Pharmacy Services Kineret® 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 :	NAME:
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	DEA: NPI:
HOME PHONE:	ALT PHONE:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)
ADDRESS: (Street) (City) (State) (Zip Code)		TELEPHONE:	FAX:
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:		*Is your fax machine kept in a secure location? <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.		*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION

KINERET® (Anakinra - J3490) 100 mg Prefilled Syringe	DIRECTIONS: <input type="checkbox"/> Inject 100 mg SC every day <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**
	SUPPLIES NEEDED (if medication is to be administered in patient's home): If checked, please specify the size and type (if applicable): <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <input type="checkbox"/> 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)

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

PRESCRIPTION INFORMATION (Continued)

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

Diagnosis related to use (please specify):

- Rheumatoid Arthritis = 714.0 (ICD-9)
- Other (please specify diagnosis and ICD-9 code): _____

Rheumatoid Arthritis:

Does the patient have a history of positive clinical response to Kineret therapy? Yes 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:

- Methotrexate Azathioprine Gold Hydroxychloroquine
- Penicillamine Sulfasalazine Other (please specify): _____

Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists?

- *Humira (adalimumab) *Enbrel (etanercept)

Additional pertinent 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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