



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:	
HEALTH CARE ID #:	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
HOME PHONE:	ALT PHONE:	DEA:	NPI:
ADDRESS: (Street) (City) (State) (Zip Code)		TELEPHONE:	FAX:
ALLERGIES: <small>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.</small>		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"/> No <input type="checkbox"/> Yes		*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	
LOCAL HOME HEALTH AGENCY:		TELEPHONE:	

PRESCRIPTION INFORMATION		
* AVONEX® 30mcg (Interferon Beta-1a - J1825) <input type="checkbox"/> 30 mcg/0.5 ml Prefilled Syringe <input type="checkbox"/> 30 mcg/1 ml Lyophilized Powder Vial <small>Note concentration of Syringe vs. Vial</small>	DIRECTIONS: <input type="checkbox"/> Inject 30 mcg IM weekly <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* COPAXONE® 20mg (Glatiramer Acetate - J1595)	<input type="checkbox"/> Inject 20 mg SC every day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* REBIF® TITRATION PACK (Interferon Beta-1a - J1825)	<input type="checkbox"/> Titration Schedule: Inject 8.8 mcg SC TIW weeks 1&2 then inject 22 mcg SC three times per week for weeks 3&4 <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply with no refills
* REBIF® 22 MCG (Interferon Beta-1a - J1825)	<input type="checkbox"/> Inject 22mcg SC three times per week <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* REBIF® 44 MCG (Interferon Beta-1a - J1825)	<input type="checkbox"/> Inject 44mcg SC three times per week <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
BETASERON® 0.3mg (Interferon Beta-1b - J1830)	<input type="checkbox"/> Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter <input type="checkbox"/> Inject 0.25 mg (1ml) SC every other day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
EXTAVIA® 0.3mg (Interferon Beta-1b)	<input type="checkbox"/> Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter <input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills

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

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

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

What is the patient's diagnosis related to use?

- Clinically Definite Multiple Sclerosis Relapsing remitting Multiple Sclerosis Clinically isolated syndrome
 Secondary Progressive Multiple Sclerosis with Relapses Other

Is this for new treatment or a continuation of therapy?

- New treatment Continuation of therapy

Please list the start date of therapy:

If there has been failure, contraindication or intolerance to any prior therapies, please check all that apply:

- Avonex
 Rebif
 Copaxone
 Other (please specify):

Will the patient be taking additional therapies concurrently for the above diagnosis? Yes No

***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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