

CIGNA Specialty Pharmacy Services Oncology 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:	DEA #:	NPI:
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
HOME PHONE:					
WORK PHONE:	ALT PHONE:		TELEPHONE:	FAX:	
ADDRESS: (Street) (City) (State) (Zip Code)			Medications shipped to MD office unless otherwise specified <input type="checkbox"/> Other Shipping address:		
ALLERGIES:			HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes		
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.			LOCAL HOME HEALTH AGENCY:	TELEPHONE:	

PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH	DOSE AND DIRECTIONS	NUMBER OF DOSES	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: _____		

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

Please specify the diagnosis and ICD-9 code:

Formulary alternatives tried:

What past conventional therapies (if any) has the patient tried?

Additional pertinent information:

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