

CIGNA Specialty Pharmacy Services
Orencia® 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:	TELEPHONE:	FAX:
Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.			
ADDRESS: (Street) (City) (State) (Zip Code)	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
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"/> Patient's Home <small>If "Physician's Office" is selected please indicate if you can only accept delivery on specific days</small>		
* 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	
PRESCRIPTION INFORMATION			
Subcutaneous ORENCIA® dosing 250 mg Vial (Abatacept - J0129) and 125mg Syringe (Abatacept – J0129)			
INITIAL DOSING with IV LOADING DOSE: SELECT DOSE FOR INITIAL LOADING DOSE (PATIENT WEIGHT/DOSE): <input type="checkbox"/> <60kg = 500 mg <input type="checkbox"/> 60-100kg = 750 mg <input type="checkbox"/> >100 kg = 1000 mg DIRECTIONS: <input type="checkbox"/> Infuse loading dose initially, then inject 125mg SQ within a day then inject 125mg SQ one time per week <input type="checkbox"/> Other: QUANTITY: <input type="checkbox"/> Dispense initial IV loading dose and 4 doses of 125mg SQ (1 month supply) _____ refills <input type="checkbox"/> Dispense initial IV loading dose and 12 doses of 125mg SQ (3 month supply) _____ refills <small>**3 month supplies of medications can result in lower copays for the member**</small>	DOSING without IV LOADING DOSE: DIRECTIONS: <input type="checkbox"/> Inject 125mg SQ one time per 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 _____ # of doses _____ refills <small>**3 month supplies of medications can result in lower copays for the member**</small>		
PHYSICIAN'S PRINTED NAME:		DATE:	
PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription 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.

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
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Intravenous ORENCIA® dosing 250 mg Vial (Abatacept - J0129)

<p>Intravenous ORENCIA® dosing 250 mg Vial (Abatacept - J0129)</p> <p>PATIENT WEIGHT/DOSE</p> <p><input type="checkbox"/> <60kg = 500 mg</p> <p><input type="checkbox"/> 60-100kg = 750 mg</p> <p><input type="checkbox"/> >100 kg = 1000 mg</p> <p>For pediatric patients weighing less than 75 kg, dose at 10mg/kg Weight _____ <input type="checkbox"/> kg <input type="checkbox"/> lb _____ Dose</p>	<p>INITIAL IV DOSING:</p> <p>DIRECTIONS: <input type="checkbox"/> Infuse initially, then at 2 weeks and 4 weeks after the first infusion.</p> <p> <input type="checkbox"/> Other:</p> <p>QUANTITY: <input type="checkbox"/> Dispense initial dose 1, 2 & 3</p> <p> <input type="checkbox"/> Other _____ # of doses _____ refills</p> <hr/> <p>MAINTENANCE IV DOSING:</p> <p>DIRECTIONS: <input type="checkbox"/> Infuse every 4 weeks</p> <p> <input type="checkbox"/> Other:</p> <p>QTY/REFILLS: <input type="checkbox"/> 1 month supply _____ refills</p> <p> <input type="checkbox"/> 3 month supply _____ refills</p> <p> <input type="checkbox"/> Other _____ # of doses _____ refills</p> <p><small>**3 month supplies of medications can result in lower copays for the member**</small></p>
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SUPPLIES NEEDED *(if medication is to be administered in patient's home):*

Needles Swabs Sharps Container Other

If checked, please specify the size and type (if applicable)

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

PHYSICIAN'S PRINTED NAME:	DATE:
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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

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
PRESCRIPTION INFORMATION (Continued)		
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:		
Diagnosis related to use (please specify): <input type="checkbox"/> Rheumatoid Arthritis = 714.0 (ICD-9) <input type="checkbox"/> Juvenile Idiopathic Arthritis <input type="checkbox"/> Other (please specify diagnosis and ICD-9 code): _____		
Rheumatoid Arthritis and Juvenile Idiopathic Arthritis: Does the patient have a history of beneficial clinical response to Orencia 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"/> Penacillamine <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other (please specify): _____ Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists? <input type="checkbox"/> *Humira (adalimumab) <input type="checkbox"/> *Enbrel (etanercept) What is the patient's current weight? Additional pertinent information:		
HOME HEALTH SERVICES INFORMATION		
HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	LOCAL HOME HEALTH AGENCY:	TELEPHONE:

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