

**CIGNA Specialty Pharmacy Services**  
**Remicade® 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.		* 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	
ADDRESS: (Street) (City) (State) (Zip Code)	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
ALLERGIES:  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"/> Patient's Home  If "Physician's Office" is selected please indicate if you can only accept delivery on specific days		

**PRESCRIPTION INFORMATION**

**REMICADE® (Infliximab - J1745) 100 mg vial**  
**Induction Dose:** Weight: \_\_\_\_\_  kg  lb      Dose: \_\_\_\_\_ mg/kg      Total Dose: \_\_\_\_\_ mg

**DIRECTIONS:**

Quantity/Refills:  6 week supply and 0 refills     Other--Number of Doses: \_\_\_\_\_ with \_\_\_\_\_ refills

**REMICADE® (Infliximab - J1745) 100 mg vial**  
**Maintenance Dose:** Weight: \_\_\_\_\_  kg  lb      Dose: \_\_\_\_\_ mg/kg      Total Dose: \_\_\_\_\_ mg

**DIRECTIONS:**

Quantity:  8 week supply     Other--Number of Doses: \_\_\_\_\_      Refills:  1 year     Other \_\_\_\_\_

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

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
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**PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:**

**Diagnosis related to use (please specify):**

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Ankylosing Spondylitis
<input type="checkbox"/> Chronic Plaque Psoriasis	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Fistulizing Crohn's disease	<input type="checkbox"/> Inflammatory Bowel Disease Arthritis	<input type="checkbox"/> Other (please specify):

What is the diagnosis code (ICD-9)?  
 What is the patient's current weight?  
 Has this patient been on Remicade in the past?  Yes  No  
 If YES, what was the previous dosage?  
 Does the patient have history of positive clinical response to Remicade (infliximab) therapy?  Yes  No  
 Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists?  
 \*Humira  \*Enbrel

**Psoriatic or Reactive Arthritis:**  
 Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy?  Yes  No

**Rheumatoid Arthritis:**  
 Will this medication be used in combination with Methotrexate 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  
 Penacillamine  Sulfasalazine  Other (please specify):

**Chronic Plaque Psoriasis:**  
 Is the patient a candidate for systemic therapy?  Yes  No  
 Has the patient received either Phototherapy or Systemic Therapy?  Yes  No

**Crohn's Disease:**  
 Has the patient had failure, contraindication, or intolerance to conventional therapies such as aminosalicylate, corticosteroids, or immunomodulators?  
 Yes  No If YES, please specify which medications:

**Fistulizing Crohn's Disease:**  
 How long have fistulas persisted?

**Inflammatory Bowel Disease Arthritis:**  
 Has the patient had failure, contraindication, or intolerance to sulfasalazine, azathioprine, steroids, or, methotrexate?  
 Yes  No

**Ankylosing Spondylitis:**  
 Has the patient had failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs)?  
 Yes  No

**Ulcerative colitis:**  
 Has the patient had failure, contraindication, or intolerance to conventional therapies such as corticosteroids (e.g, prednisone, methylprednisolone), 5-aminosalicylic acid agents (e.g., sulfasalazine, mesalamine, balsalazide), or immunosuppressants (e.g., azathioprine, cyclosporine, 6-mercaptopurine)?  
 Yes  No If YES, please specify which medications:

**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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