

CIGNA Specialty Pharmacy Services Rituxan® 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: <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>		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes			
PATIENT HEIGHT:	PATIENT WEIGHT:	LOCAL HOME HEALTH AGENCY:	TELEPHONE:		

PRESCRIPTION INFORMATION				
MEDICATION	STRENGTH	DOSE AND DIRECTIONS	NUMBER OF DOSES	REFILLS
RITUXAN® (Rituximab)				

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

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

