

CIGNA Specialty Pharmacy Services Vectibix® 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:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
WORK PHONE:	ALT PHONE:	TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		*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 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.	
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
VECTIBIX® (panitumumab)				

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

CLINICAL INFORMATION

Is this a new start? Yes No

Start date:

Frequency of therapy:

Length of therapy:

What is the patient's current weight?

Will this medication be given concurrently with other agents? Yes No

If yes, please specify:

Is the patient a candidate for home infusion? Yes No

Does the provider have an in-office infusion site? Yes No

What is the patient's diagnosis?

Colorectal Cancer Small Bowel Adenocarcinoma Other (please specify):

Does the patient have advanced or metastatic disease? Yes No

Does the patient have wild-type KRAS (Kirsten rat sarcoma) gene? Yes No

Additional Information: