

CIGNA Specialty Pharmacy Services Avastin® 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
AVASTIN® (bevacizumab)				

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

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
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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?
 Non Small Cell Lung Cancer Colorectal Cancer Breast Cancer Ovarian Cancer Renal Cell Cancer
 Other (please specify): _____

If being used for non-small cell lung cancer is the cancer recurrent or metastatic? Yes No

If being used for breast cancer does the patient have metastatic disease? Yes No

If being used for breast cancer is the breast cancer HER2 negative? Yes No

If being used for renal, colorectal or ovarian cancer does the patient have metastatic disease? Yes No

Additional pertinent information: _____