

**CIGNA Specialty Pharmacy Services**  
**Multiple Sclerosis Fax Order Form**



Please deliver by: \_\_\_\_\_

Requests received after 4 p.m. CT will begin processing the following business day

Order #: \_\_\_\_\_ Referral Source Code: **652**

Fax: 1.800.351.3616

Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:		DATE OF BIRTH:	
HEALTH CARE ID #:		GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	
HOME PHONE:		TELEPHONE:	
		FAX:	
		*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: <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 Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.</small>	

PRESCRIPTION INFORMATION		
* <b>AVONEX® 30mcg</b> (Interferon Beta-1a - J1825) <input type="checkbox"/> 30 mcg/0.5 ml Prefilled Syringe <input type="checkbox"/> 30 mcg/1 ml Lyophilized Powder Vial <small>Note concentration of Syringe vs. Vial</small>	DIRECTIONS: <input type="checkbox"/> Inject 30 mcg IM weekly <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* <b>COPAXONE® 20mg</b> (Glatiramer Acetate - J1595)	<input type="checkbox"/> Inject 20 mg SC every day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* <b>REBIF® TITRATION PACK</b> (Interferon Beta-1a - J1825)	<input type="checkbox"/> Titration Schedule: Inject 8.8 mcg SC TIW weeks 1&2 then inject 22 mcg SC three times per week for weeks 3&4 <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply with no refills
* <b>REBIF® 22 MCG</b> (Interferon Beta-1a - J1825)	<input type="checkbox"/> Inject 22mcg SC three times per week <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
* <b>REBIF® 44 MCG</b> (Interferon Beta-1a - J1825)	<input type="checkbox"/> Inject 44mcg SC three times per week <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<b>BETASERON® 0.3mg</b> (Interferon Beta-1b - J1830)	<input type="checkbox"/> Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter <input type="checkbox"/> Inject 0.25 mg (1ml) SC every other day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<b>EXTAVIA® 0.3mg</b> (Interferon Beta-1b)	<input type="checkbox"/> Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter <input type="checkbox"/> Inject 0.25mg (1ml) SC every other day <input type="checkbox"/> Other:	<input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills

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

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:	CIGNA ID #	DATE OF BIRTH:
<b>PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:</b>		
<p><b>What is the patient's diagnosis related to use?</b></p> <p> <input type="checkbox"/> Clinically Definite Multiple Sclerosis    <input type="checkbox"/> Relapsing remitting Multiple Sclerosis    <input type="checkbox"/> Clinically isolated syndrome  <input type="checkbox"/> Secondary Progressive Multiple Sclerosis with Relapses    <input type="checkbox"/> Other </p> <p><b>Is this for new treatment or a continuation of therapy?</b></p> <p> <input type="checkbox"/> New treatment    <input type="checkbox"/> Continuation of therapy </p> <p><b>Please list the start date of therapy:</b></p> <p><b>If there has been failure, contraindication or intolerance to any prior therapies, please check all that apply:</b></p> <p> <input type="checkbox"/> Avonex  <input type="checkbox"/> Rebif  <input type="checkbox"/> Copaxone  <input type="checkbox"/> Other (please specify): </p> <p>Will the patient be taking additional therapies concurrently for the above diagnosis?    <input type="checkbox"/> Yes    <input type="checkbox"/> No </p>		
<b>HOME HEALTH SERVICES INFORMATION</b>		
<b>HOME HEALTH SERVICES REQUIRED?</b>	LOCAL HOME HEALTH AGENCY:	TELEPHONE:
<input type="checkbox"/> No <input type="checkbox"/> Yes		

**\*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.

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