

# CIGNA Specialty Pharmacy Services - Hepatitis C 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 :	
HEALTH CARE ID #:		GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	
HOME PHONE:		ALT PHONE:	
ADDRESS: (Street) (City) (State) (Zip Code)		NAME:	
		DEA #:	
		NPI:	
		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
TELEPHONE:		FAX:	
ADDRESS: (Street) (City) (State) (Zip Code)		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
		LOCAL HOME HEALTH AGENCY:	
		TELEPHONE:	
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"/> Member's Home <small>Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.</small>	
*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	

PRESCRIPTION INFORMATION		
<p><b>* PEGASYS®</b> (Peginterferon Alfa-2a - S0145):</p> <input type="checkbox"/> 180 mcg/0.5 ml Prefilled Syringe <input type="checkbox"/> 180 mcg/1 ml Vial <b>Note: Concentration of Syringe vs. Vial</b>	<p>DIRECTIONS:</p> <input type="checkbox"/> Inject 180 mcg SQ weekly <input type="checkbox"/> Other (please specify):	<p>QTY/REFILLS</p> <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<p><b>* PEG-INTRON®</b> (Peginterferon Alfa-2b - S0146):</p> <input type="checkbox"/> 50 mcg/0.5 ml Vial <input type="checkbox"/> 50 mcg/0.5 ml Redipen <input type="checkbox"/> 80 mcg/0.5 ml Vial <input type="checkbox"/> 80 mcg/0.5 ml Redipen <input type="checkbox"/> 120 mcg/0.5 ml Vial <input type="checkbox"/> 120 mcg/0.5 ml Redipen <input type="checkbox"/> 150 mcg/0.5 ml Vial <input type="checkbox"/> 150 mcg/0.5 ml Redipen	<p>DIRECTIONS:</p> <input type="checkbox"/> Inject 0.4 ml SQ weekly <input type="checkbox"/> Inject 0.5 ml SQ weekly <input type="checkbox"/> Other (please specify):	<p>QTY/REFILLS</p> <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<p><b>INFERGEN®</b> (Interferon Alfacon-1 - J9212):</p> <input type="checkbox"/> 9 mcg/0.3 ml Vial <input type="checkbox"/> 15 mcg/0.5 ml Vial	<p>DIRECTIONS:</p> <input type="checkbox"/> Inject 9 mcg SQ 3 times per week <input type="checkbox"/> Inject 15 mcg SQ 3 times per week <input type="checkbox"/> Other (please specify):	<p>QTY/REFILLS</p> <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):** If checked, please specify the size and type (if applicable):

Syringes/Needles  Swabs  Sharps Container  Other:

PHYSICIAN'S PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
<b>PRESCRIPTION INFORMATION CONTINUED</b>		
<b>SELECT A RIBAVIRIN:</b> <input type="checkbox"/> <b>Rebetol®</b> 200 mg capsules <input type="checkbox"/> <b>Copegus®</b> 200 mg tablets	<b>DIRECTIONS:</b> ____ QAM AND ____ QPM	<b>QTY/REFILLS</b> <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<b>VICTRELIS</b> (Boceprevir) <input type="checkbox"/> 200 mg capsules	<b>DIRECTIONS:</b> <input type="checkbox"/> Take 800mg (4 capsules) by mouth 3 times a day with food <input type="checkbox"/> Other (please specify):	<b>QTY/REFILLS</b> <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<b>INCIVEK</b> (Telaprevir) <input type="checkbox"/> 375 mg tablets	<b>DIRECTIONS:</b> <input type="checkbox"/> Take 750mg (2 tablets) by mouth 3 times a day with food. <input type="checkbox"/> Other (please specify):	<b>QTY/REFILLS</b> <input type="checkbox"/> 1 month supply ____ refills <input type="checkbox"/> 3 month supply ____ refills <input type="checkbox"/> Other: ____ QTY ____ refills
<b>PHYSICIAN'S SIGNATURE:</b> (Physician's signature indicates accuracy and completeness of prescription information)		
In order for a brand name product to be dispensed, the prescriber must handwrite " <b>Brand Necessary</b> " or " <b>Brand Medically Necessary</b> " on the prescription		

**PRESCRIPTION INFORMATION (Continued)**

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

**MARK THE DIAGNOSIS:**  
 Hepatitis C = 070.54 (ICD-9)     Hepatitis B = 070. (ICD-9)     Other (List Diagnosis ICD-9): \_\_\_\_\_

Does this patient have an HIV co-infection?     Yes     No

**For Infergen requests only:**  
 Did the patient have intolerance to treatment with PegaSys or Peg-Intron?     Yes     No

**If diagnosis is Hepatitis C, please complete the following questions:**  
 What is the patient's Genotype?  
 Type 1     Type 2     Type 3     Type 4     Type 5     Type 6     Genotype unknown

What is the individual's current weight?  
 Does the individual have compensated liver disease?     Yes     No

Does this patient have bridging fibrosis?     Yes     No

Does this patient have cirrhosis?     Yes     No

Does this patient have steatosis?     Yes     No

Has the patient already started treatment on the requested medication?     Yes     No

If yes, what date did treatment begin? (please specify): \_\_\_\_\_

**Lab values:**  
 Please specify the patient's Quantitative HCV RNA value at each of the following phases of treatment. (Please note that at initiation of therapy CIGNA Pharmacy Services only needs the patient's pre-treatment lab values; subsequent values should be obtained throughout the patient's treatment).

Treatment Phase	Date lab assessed	Lab Value (in IU/ml)
Pre-treatment		
12 weeks – 16 weeks		
24 weeks – 28 weeks		
Other:		
Other:		
Post treatment (24 weeks after end of therapy for documentation of sustained virologic response)		

Additional pertinent information:

PHYSICIAN'S PRINTED NAME:	DATE:
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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

**\*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.