

CIGNA Specialty Pharmacy Services
Infertility 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:	
ANONYMOUS DONOR MEDICATIONS: Please send in separate forms for patient and anonymous donor medications. <input type="checkbox"/> Medications on this form are for the anonymous donor. Anonymous donor number _____		DEA #:	NPI:
HEALTH CARE ID #:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	TELEPHONE:	FAX:
HOME PHONE: _____ ALT PHONE: _____	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.			
ADDRESS: (Street) (City) (State) (Zip Code)		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home If "Physician's Office" is selected please indicate if you can only accept delivery on specific days	
ALLERGIES:		DONOR ALLERGIES:	
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.			
*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	
*FOLLISTIM AQ® (Follitropin Beta - S0128) <input type="checkbox"/> 75 IU Vials	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> 150 IU Vials	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> 300 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> 600 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> 900 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> *GANIRELIX® 250 mcg Syringe (Ganirelix Acetate - S0132)	DIRECTIONS:	QTY:	REFILLS:
CETROTIDE® (Cetrorelix Acetate - J3490) <input type="checkbox"/> 0.25 mg Syringe	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> 3 mg Syringe	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> CLOMID® 50 mg Tablets (Clomiphene Citrate - J3490)	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> CRINONE® 8% Vaginal Gel (Progesterone - J2675)	DIRECTIONS:	QTY:	REFILLS: *Dispensed in boxes of 15 applicators*
<input type="checkbox"/> DOXYCYCLINE TAB (J3490) _____ mg	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> ENDOMETRIN® 100mg Vaginal Insert (Progesterone - J3490)	DIRECTIONS:	QTY:	REFILLS: **Dispensed in packs of 21 inserts**
<input type="checkbox"/> ESTRACE® TAB (Estradiol - J3490) _____ mg	DIRECTIONS:	QTY:	REFILLS:
<input type="checkbox"/> BRAVELLE® 75 IU vial (Urofollitropin - J3355)	DIRECTIONS:	QTY:	REFILLS:
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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PRESCRIPTION INFORMATION (Continued)

<input type="checkbox"/> GONAL-F® (Follitropin Alfa – S0126)		
<input type="checkbox"/> RFF 75 IU single-dose syringe	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> RFF Pen 300 IU/0.5 ml	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> RFF Pen 450 IU/0.75 ml	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> RFF Pen 900 IU/1.5 ml	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> 450 IU multi-dose vial kit	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> 1050 IU multi-dose vial kit	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> HCG (Human Chorionic Gonadotropin) 10,000 Unit multi-dose vial (J0725) <i>see note at bottom of this page</i>	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> LEUPROLIDE 2 Week Kit (Leuprolide Acetate - J9218)	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> LUPRON® MICRODOSE (COMPOUND) (J3490) Strength: _____ Good for 30 days after it is made, anticipated start date of Lupron Microdose _____	DIRECTIONS:	QTY: (please indicate number of mls to dispense) REFILLS:
<input type="checkbox"/> LUVERIS® 75 IU vial (Lutropin alfa - J3490)	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> MEDROL® (Methylprednisolone - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> MENOPUR® 75 IU vial (Menotropins - J3490)	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> OVIDREL® 250mcg pre-filled syringe (Choriogonadotropin Alfa - J3490) <i>see note at bottom of this page</i>	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PREDNISONE® TAB (Prednisone - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PRENATAL PLUS® TABS (prenatal vitamin with iron - J3490)	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PROGESTERONE VAGINAL SUPPOSITORY (COMPOUND) (J3490) Strength: _____	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PROGESTERONE IN SESAME OIL 50 mg/ml vial (J2675)	DIRECTIONS:	QTY: REFILLS:
PROGESTERONE IN OIL (COMPOUND) *Cannot supply in Ethyl oleate <input type="checkbox"/> 50mg/ml <input type="checkbox"/> 100mg/ml Oil: _____	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> PROMETRIUM® (Micronized Progesterone - J3490) <input type="checkbox"/> 100 mg capsules	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> 200 mg capsules	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> REPRONEX® 75 IU Vial (Menotropins - S0122)	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> VALIUM® TAB (Diazepam - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> VIVELLE® DOT PATCH _____ mg	DIRECTIONS:	QTY: REFILLS: *Dispensed in boxes of 8 patches*
<input type="checkbox"/> ZITHROMAX® TAB (Azithromycin – J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
<input type="checkbox"/> OTHER (specify drug name & J-Code)	DIRECTIONS:	QTY: REFILLS:

PATIENT PARTNER PRESCRIPTION INFORMATION

PATIENT PARTNER NAME:	PATIENT PARTNER DATE OF BIRTH:
PATIENT PARTNER ALLERGIES:	PATIENT PARTNER HEALTH CONDITIONS:
<input type="checkbox"/> MEDICATION FOR PARTNER (specify drug name & J-Code)	DIRECTIONS: QTY: REFILLS:

PRESCRIBER'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
NOTE: we are unable to accept faxed prescriptions for Novarel, Ovidrel, Pregnyl, or any HCG compound from any NY prescriber OR for any NY patient.

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PRESCRIPTION INFORMATION (Continued)

SUPPLIES NEEDED (if medication is to be administered in patient's home):

SYRINGES			NEEDLES		
<input type="checkbox"/> 1 cc Syringe (no needle)	QTY:	REFILLS:	<input type="checkbox"/> 18g 1 1/2" Needles	QTY:	REFILLS:
<input type="checkbox"/> 1 cc Syringe 27g 1/2"	QTY:	REFILLS:	<input type="checkbox"/> 22g 1 1/2" Needles	QTY:	REFILLS:
<input type="checkbox"/> 3 cc Syringe 22g 1"	QTY:	REFILLS:	<input type="checkbox"/> 23g 1" Needles	QTY:	REFILLS:
<input type="checkbox"/> 3 cc Syringe 22g 1 1/2"	QTY:	REFILLS:	<input type="checkbox"/> 25g 5/8" Needles	QTY:	REFILLS:
<input type="checkbox"/> 3 cc Syringe 25g 1"	QTY:	REFILLS:	<input type="checkbox"/> 25g 1 1/2" Needles	QTY:	REFILLS:
<input type="checkbox"/> 3 cc Syringe (no needle)	QTY:	REFILLS:	<input type="checkbox"/> 27g 1/2" Needles	QTY:	REFILLS:
INSULIN SYRINGES			<input type="checkbox"/> 30g 1/2" Needles	QTY:	REFILLS:
<input type="checkbox"/> 1/2 cc 28g 1/2" (Monoject)	QTY:	REFILLS:	<input type="checkbox"/> 29g 1/2" Pen Needles	QTY:	REFILLS:
<input type="checkbox"/> 3/10 cc 30g 1/2"	QTY:	REFILLS:	<input type="checkbox"/> SWABS	QTY: 100	REFILLS:
<input type="checkbox"/> 1/2 cc 30g 1/2"	QTY:	REFILLS:	<input type="checkbox"/> SHARPS CONTAINER	QTY: 1	REFILLS:
<input type="checkbox"/> 1 cc 30g 1/2"	QTY:	REFILLS:			

Answer the following questions on all requests with a diagnosis of female infertility.

What is the patient's diagnosis?
 Infertility Other (please specify):

What type of treatment is the patient undergoing?

What is the anticipated start date of the patient's treatment cycle?

Answer the following question on requests for Gonal-F and Bravelle.

Does the patient have failure, contraindication or intolerance to Follistim AQ? Yes No

Please fax completed form to (800)351-3616. View our formulary on line at <http://www.cigna.com>.

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

***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.