

CIGNA Specialty Pharmacy Services
Remicade® 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:	ALT PHONE:	TELEPHONE:	FAX:
<small>Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.</small>			
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</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	
REMICADE® (Infliximab - J1745) 100 mg vial	
Induction Dose: Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb	Dose: _____ mg/kg Total Dose: _____ mg
DIRECTIONS:	
Quantity/Refills: <input type="checkbox"/> 6 weeks supply and 0 refills <input type="checkbox"/> Other--Number of Doses: _____ with _____ refills	
REMICADE® (Infliximab - J1745) 100 mg vial	
Maintenance Dose: Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb	Dose: _____ mg/kg Total Dose: _____ mg
DIRECTIONS:	
Quantity: <input type="checkbox"/> 8 week supply <input type="checkbox"/> Other--Number of Doses: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other _____	
SUPPLIES NEEDED (if medication is to be administered in patient's home) If checked, please specify the size and type (if applicable)	
<input type="checkbox"/> Syringes/Needles <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <input type="checkbox"/> Other	
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	

***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.

PATIENT NAME:		HEALTH CARE ID #:	DATE OF BIRTH:
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:			
Diagnosis related to use (please specify):			
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	
<input type="checkbox"/> Chronic Plaque Psoriasis	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Crohn's disease	
<input type="checkbox"/> Fistulizing Crohn's disease	<input type="checkbox"/> Inflammatory Bowel Disease Arthritis	<input type="checkbox"/> Other (please specify):	
What is the diagnosis code (ICD-9)?			
What is the patient's current weight?			
Has this patient been on Remicade in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, what was the previous dosage?			
Does the patient have history of positive clinical response to Remicade (infliximab) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists?			
<input type="checkbox"/> *Humira <input type="checkbox"/> *Enbrel			
Psoriatic or Reactive Arthritis:			
Does patient have evidence of failure, intolerance or contraindication to Methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Rheumatoid Arthritis:			
Will this medication be used in combination with Methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate if the patient has had evidence of failure, inadequate response, intolerance or contraindication to any of the following disease-modifying anti-rheumatic drugs (DMARDs). Please check all that apply:			
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Azathioprine	<input type="checkbox"/> Gold	<input type="checkbox"/> Hydroxychloroquine
<input type="checkbox"/> Penacillamine	<input type="checkbox"/> Sulfasalazine	<input type="checkbox"/> Other (please specify):	
PATIENT NAME:		CIGNA ID #:	DATE OF BIRTH:
Chronic Plaque Psoriasis:			
Is the patient a candidate for systemic therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the patient received either Phototherapy or Systemic Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Crohn's Disease:			
Has the patient had failure, contraindication, or intolerance to conventional therapies such as aminosalicylate, corticosteroids, or immunomodulators? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please specify which medications:			
Fistulizing Crohn's Disease:			
How long have fistulas persisted?			
Inflammatory Bowel Disease Arthritis:			
Has the patient had failure, contraindication, or intolerance to sulfasalazine, azathioprine, steroids, or, methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ankylosing Spondylitis:			
Has the patient had failure, contraindication, or intolerance to non-steroidal anti-inflammatory drugs (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ulcerative colitis:			
Has the patient had failure, contraindication, or intolerance to conventional therapies such as corticosteroids (e.g, prednisone, methylprednisolone), 5-aminosalicylic acid agents (e.g., sulfasalazine, mesalamine, balsalazide), or immunosuppressants (e.g., azathioprine, cyclosporine, 6-mercaptopurine)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please specify which medications:			
Additional pertinent information:			
HOME HEALTH SERVICES INFORMATION			
HOME HEALTH SERVICES REQUIRED?		LOCAL HOME HEALTH AGENCY:	TELEPHONE:
<input type="checkbox"/> No <input type="checkbox"/> Yes			

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