Cigna Specialty Pharmacy Services Fax Order Form

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	
PATIENTNAME:	DATE OF BIRTH:	NAME:	
HEALTH CARE ID #:	SEX: ☐ M ☐ F	DEA #:	NPI:
HOME PHONE: ALT PHONE: Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.		TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
		Physician office hours:	
ALLERGIES: If no allergies are specified, for new customers this means no known allergies and for existing customers this means no change from information provided to Cigna Specialty pharmacy previously.		**SHIP MEDICATIONS TO:** ☐ Physician's Office ☐ Patient's Home If "Physician's Office" is selected please indicate if you can only accept delivery on specific days	

PRESCRIPTION INFORMATION

DRUG		DIRECTIONS	QTY/REFILLS
Aptivus ☐ 250mg capsules ☐ 100mg/ml oral solution			
☐ Atripla 600-200-300mg tablets			
☐ Combivir 150-300mg tablets			
☐ Complera 200-25-300mg tablets			
Crixivan ☐ 200mg capsules ☐ 400mg capsules			**QTY/REFILLS (meds on this page)** ☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ______QTY _____ refills **3 month supplies of medications can result in lower copays for the member**
☐ Edurant 25mg tablets			
Emtriva ☐ 200mg capsules ☐ 10mg/ml oral solution			
Epivir ☐ 150mg tablets ☐ 300mg tablets ☐ 10mg/ml oral solution			
☐ Epzicom 600-300mg tablets			
☐ Fuzeon 90mg/cc Pediatric dosing - Refer to product information	Supplies ☐ Swabs	☐ Inject 1cc SC BID ☐ Other:	
Intelence ☐ 100mg tablets ☐ 200mg tablets			
Invirase ☐ 200mg capsules ☐ 500mg tablets			
☐ Isentress 400mg tablets			

Physician's PRINTED NAME: DATE:

Physician's SIGNATURE: (Physician's signature shows 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

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PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:

PRESCRITPTION INFORMATION CONTINUED

DRUG	DIRECTIONS	QTY/REFILLS
Kaletra ☐ 100-25mg tablets ☐ 200-50mg tablets ☐ 80mg-20mg per ml oral solution		
Lexiva ☐ 700mg tablets ☐ 50mg/ml oral suspension		
Norvir ☐ 100mg tablets (non-refrigerated) ☐ 100mg softgel capsules (REFRIGERATE) ☐ 80mg/ml oral solution		
Prezista ☐ 75mg tablets ☐ 150mg tablets ☐ 600mg tablets (SIX hundred mg) ☐ 800mg tablets (EIGHT hundred mg)		
☐ Rescriptor 200mg tablets		**QTY/REFILLS (meds on this page)**
Retrovir ☐ 100mg capsules ☐ 300mg tablets ☐ 10mg/ml oral syrup		☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ______QTY _____ refills
Reyataz ☐ 100mg capsules ☐ 150mg capsules ☐ 200mg capsules ☐ 300mg capsules		**3 month supplies of medications can result in lower copays for the member**
Selzentry ☐ 150mg tablets ☐ 300mg tablets		
Serostim **Recommended dose based on patient weight** >55kg (>121 lbs) ☐ Inject 6mg SQ daily 45 - 55kg (99 - 121 lbs) ☐ Inject 5mg SQ daily 35 - 45kg (75 – 99 lbs) ☐ Inject 4mg SQ daily <35kg (<75 lbs) 0.1mg/kg QD ☐ Inject _____mg SQ daily	Supplies ☐ 1cc syringe, 20g 1” needle & 27g ½” needle ☐ Swabs ☐ Other (specify)	
☐ Stribild 150mg-150mg-200mg-300mg tablets		
Sustiva ☐ 50mg capsules ☐ 200mg capsules ☐ 600mg tablets		
☐ Trizivir 300-150-300mg tablets		
☐ Truvada 200-300mg tablets		
Videx EC ☐ 125mg capsules ☐ 200mg capsules ☐ 250mg capsules ☐ 400mg capsules		
☐ Plain Videx 10mg/ml powder for oral solution		
Viracept ☐ 250mg tablets ☐ 625mg tablets		
Plain Viramune ☐ 200mg tablets ☐ 50mg/5ml oral suspension		
☐ Viramune XR (Extended Release) 400mg tablets		
Viread ☐ 150mg tablets ☐ 200mg tablets ☐ 250mg tablets ☐ 300mg tablets ☐ 40mg/scoop powder		
Zerit ☐ 15mg capsules ☐ 20mg capsules ☐ 30mg capsules ☐ 40mg capsules ☐ 1mg/1ml oral solution		
Ziagen ☐ 300mg tablets ☐ 20mg/ml oral solution		

Physician’s PRINTED NAME:	DATE:
Physician’s SIGNATURE: (Physician’s signature shows accuracy and completeness of prescription information)	

☐	**AIDS Wasting (Serostim Only)**	
Additional Question(s)	What was the patient's **pre-treatment baseline body weight**?	Additional Details:
	What is the patient's **current body weight**?	Additional Details:
	What is the patient's **pre-treatment body mass index**?	Additional Details:
	What is the patient's **current body mass index**?	Additional Details:
	Has this patient had failure to treatment with, or contraindication or intolerance to appetite stimulants and/or other anabolic agents? (Please provide medication details in the Additional Details section.) ☐ Yes ☐ No	Additional Details:
	Will this patient have continuous use of antiviral therapy? ☐ Yes ☐ No	Additional Details:

Physician's PRINTED NAME:	DATE:
Physician's SIGNATURE: (Physician's signature shows accuracy and completeness of prescription information)	
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