CIGNA Specialty Pharmacy Services General 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:	DEA #:
HEALTH CARE ID #:	GENDER: ☐ M ☐ F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
HOME PHONE:	ALT PHONE:	TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)		**SHIP MEDICATIONS TO:** ☐ Physician's Office ☐ Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.	
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.		**HOME HEALTH SERVICES REQUIRED?** ☐ No ☐ Yes	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION

DRUG NAME:	STRENGTH:
DOSE and DIRECTIONS:	☐ 1 Month _____ Refills ☐ 3 Months _____ Refills ☐ _____ # of Doses _____ Refills ☐ 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):

If needing diluent to mix the vial, please provide name of diluent and amount to dilute each vial. Quantity and refill will be sufficient for prescription.

☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other

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

Please specify the diagnosis and ICD-9 code:

Formulary alternatives tried:

What past conventional therapies (if any) has the patient tried?

Additional pertinent information:

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