CIGNA Specialty Pharmacy Services
Orencia® 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: ☐ M ☐ F	DEA #:	NPI:
HOME PHONE: ALT PHONE:		TELEPHONE:	FAX:
Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.		* Is your fax machine kept in a secure location? ☐ Yes ☐ No * May we fax our response to your office? ☐ Yes ☐ No	
ADDRESS: (Street) (City) (State) (Zip Code)		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
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.		**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

ORENCIA® 250 mg Vial (Abatacept - J0129)

PATIENT WEIGHT/DOSE

- ☐ <60kg = 500 mg
- ☐ 60-100kg = 750 mg
- ☐ >100 kg = 1000 mg

For pediatric patients weighing less than 75 kg, dose at 10mg/kg

Weight _________ ☐ kg ☐ lb ____________ Dose

INITIAL DOSING:

DIRECTIONS:
- ☐ Infuse initially, then at 2 weeks and 4 weeks after the first infusion.
- ☐ Other:

QUANTITY:
- ☐ Dispense initial dose 1, 2 & 3
- ☐ Other ________ # of doses _______ refills

MAINTENANCE DOSING:

DIRECTIONS:
- ☐ Infuse every 4 weeks
- ☐ Other:

QTY/REFILLS:
- ☐ 1 month supply ________ refills
- ☐ 3 month supply ________ refills
- ☐ Other __________ # of doses _______ refills

3 month supplies of medications can result in lower copays for the member

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

☐ Needles ☐ Swabs ☐ Sharps Container ☐ Other

If checked, please specify the size and type (if applicable)

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:

PRESCRIPTION INFORMATION (Continued)

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

Diagnosis related to use (please specify):

☐ Rheumatoid Arthritis = 714.0 *(ICD-9)* ☐ Juvenile Idiopathic Arthritis ☐ Other *(please specify diagnosis and ICD-9 code)*: ______

Rheumatoid Arthritis and Juvenile Idiopathic Arthritis:

Does the patient have a history of beneficial clinical response to Orencia therapy? ☐ Yes ☐ 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:

☐ Methotrexate ☐ Azathioprine ☐ Gold ☐ Hydroxychloroquine
☐ Penacillamine ☐ Sulfasalazine ☐ Other (please specify):

Has the patient had inadequate response, intolerance or contraindication to any of following Tumor Necrosis Factor (TNF) Antagonists?

☐ *Humira (adalimumab) ☐ *Enbrel (etanercept)

What is the patient's current weight?

Additional pertinent information:

HOME HEALTH SERVICES INFORMATION

HOME HEALTH SERVICES REQUIRED? ☐ No ☐ Yes	LOCAL HOME HEALTH AGENCY:	TELEPHONE:

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.