CIGNA Specialty Pharmacy Services Blood Modifier 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 #:	NPI:
HEALTH CARE ID #:	SEX: ☐ M ☐ F	ADDRESS: (Street/Suite #) (City) (State) (Zip Code)		
HOME PHONE:				
WORK 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

PROCRIT® VIALS

- ☐ 2,000 units/1 ml
- ☐ 3,000 units/1 ml
- ☐ 4,000 units/1 ml
- ☐ 10,000 units/1 ml
- ☐ 20,000 units/1 ml (multi-dose vial)
- ☐ 20,000 units/2 ml (10,000 units/1 ml multi-dose vial)
- ☐ 40,000 units/1 ml

EPOGEN® VIALS

- ☐ 2,000 units/1 ml
- ☐ 3,000 units/1 ml
- ☐ 4,000 units/1 ml
- ☐ 10,000 units/1 ml
- ☐ 20,000 units/1 ml (multi-dose vial)
- ☐ 20,000 units/2 ml (10,000 units/1 ml multi-dose vial)

ARANESP® *(Please select Vials, or Prefilled Syringe)*

Vials		Prefilled Syringes	
☐ 25 mcg/1 ml	☐ 150 mcg/0.75 ml	☐ 25 mcg/0.42 ml	☐ 150 mcg/0.3 ml
☐ 40 mcg/1 ml	☐ 200 mcg/1 ml	☐ 40 mcg/0.4 ml	☐ 200 mcg/0.4 ml
☐ 60 mcg/1 ml	☐ 300 mcg/1 ml	☐ 60 mcg/0.3 ml	☐ 300 mcg/0.6 ml
☐ 100 mcg/1 ml		☐ 100 mcg/0.5 ml	☐ 500 mcg/1 ml

*DOSE and DIRECTIONS:

*Please provide dose & directions

QTY:

REFILLS:

SUPPLIES NEEDED ***(if medication is to be administered in patient's home)*:** If checked, please specify the size and type (if applicable):

☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ 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

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

PRESCRIPTION INFORMATION (Continued)

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

Cause of Anemia:

- ☐ Chronic kidney disease
- ☐ Current cancer chemotherapy Date of chemotherapy:
- ☐ HIV infection in individuals receiving zidovudine therapy
- ☐ Surgical patients
- ☐ Myelodysplastic syndrome
- ☐ Ribavirin use
- ☐ Rheumatoid arthritis/rheumatic disease
- ☐ Individuals who will not or cannot receive blood products for treatment of acute hemorrhage or blood loss
- ☐ Other (please specify ICD-9 code):

Clinical Data:

What is the patient's Hemoglobin level? Date of the test:

For reauthorizations: What was the Hemoglobin level before treatment? Date of start of treatment:

What is the patient's serum ferritin level? Date of the test:

What is the patient's serum transferrin level? Date of the test:

Is this patient on Iron Supplementation? ☐ Yes ☐ No

Additional pertinent clinical information:

PHYSICIAN'S PRINTED NAME: DATE:

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

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