CIGNA Specialty Pharmacy Services
Multiple Sclerosis Fax Order Form

Please deliver by: _____

Requests received after 4 p.m. CT will begin processing the following business day

Order #: **Referral Source Code: 652**

CIGNA®

Fax: 1.800.351.3616
Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		**PHYSICIAN INFORMATION**	
PATIENT NAME:	DATE OF BIRTH :	NAME:	
HEALTH CARE ID #:	GENDER: ☐ M ☐ F	DEA #:	NPI:
HOME PHONE:		TELEPHONE:	FAX:
		*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 Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.	

PRESCRIPTION INFORMATION

* **AVONEX® 30mcg** (Interferon Beta-1a - J1825) ☐ 30 mcg/0.5 ml Prefilled Syringe ☐ 30 mcg/1 ml Lyophilized Powder Vial **Note concentration of Syringe vs. Vial**	DIRETIONS: ☐ Inject 30 mcg IM weekly ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills
* **COPAXONE® 20mg** (Glatiramer Acetate - J1595)	☐ Inject 20 mg SC every day ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills
* **REBIF® TITRATION PACK** (Interferon Beta-1a - J1825)	☐ Titration Schedule: Inject 8.8 mcg SC TIW weeks 1&2 then inject 22 mcg SC three times per week for weeks 3&4 ☐ Other:	☐ 1 month supply with no refills
* **REBIF® 22 MCG** (Interferon Beta-1a - J1825)	☐ Inject 22mcg SC three times per week ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills
* **REBIF® 44 MCG** (Interferon Beta-1a - J1825)	☐ Inject 44mcg SC three times per week ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills
BETASERON® 0.3mg (Interferon Beta-1b - J1830)	☐ Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter ☐ Inject 0.25 mg (1ml) SC every other day ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills
EXTAVIA® 0.3mg (Interferon Beta-1b)	☐ Inject 0.0625mg (0.25 ml) SC every other day for weeks 1 & 2, then 0.125mg (0.5 ml) every other day for weeks 3 & 4, then 0.1875mg (0.75 ml) every other day for weeks 5 & 6, then 0.25mg (1 ml) every other day thereafter ☐ Inject 0.25mg (1ml) SC every other day ☐ Other:	☐ 1 month supply _____ refills ☐ 3 month supply _____ refills ☐ Other: ____QTY ____ refills

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

☐ Swabs ☐ Sharps Container ☐ Other (If checked, please specify the size and type)

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***

(Continued on next page)

PATIENT NAME:	CIGNA ID #	DATE OF BIRTH:

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

What is the patient's diagnosis related to use?

☐ Clinically Definite Multiple Sclerosis ☐ Relapsing remitting Multiple Sclerosis ☐ Clinically isolated syndrome
☐ Secondary Progressive Multiple Sclerosis with Relapses ☐ Other

Is this for new treatment or a continuation of therapy?
☐ New treatment ☐ Continuation of therapy

Please list the start date of therapy:

If there has been failure, contraindication or intolerance to any prior therapies, please check all that apply:
☐ Avonex
☐ Rebif
☐ Copaxone
☐ Other (please specify):

Will the patient be taking additional therapies concurrently for the above diagnosis? ☐ Yes ☐ No

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.