CIGNA Specialty Pharmacy Services Synagis® Fax Order Form

Please deliver by: _____

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

Order #: **Referral Source Code:** 662

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 #:	SEX: ☐ M ☐ F		DEA:	NPI:
HOME PHONE:	ALT PHONE:		TELEPHONE:	FAX:
ADDRESS: (Street) (City) (State) (Zip Code)			ADDRESS: (Street/Suite #) (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 Tel-Drug previously.			**HOME HEALTH SERVICES REQUIRED?** ☐ No ☐ Yes LOCAL HOME HEALTH AGENCY: TELEPHONE:	

PRESCRIPTION INFORMATION

SYNAGIS® (Palivizumab C9003): ☐ Inject 15 mg/kg IM one time per month	Refills (months): ☐ Through March of current RSV season ☐ Other:	EXPECTED DATE OF INJECTION (MM/DD/YY) ***Required to ensure accurate dispensing***:
☐ Epinephrine 1:1000 ampule	☐ Inject 0.01mg/kg as directed ☐ Other _____	Qty : 1 Refills : 0 ☐ Other _____

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

☐ Syringes/Needles ☐ Swabs ☐ Sharps Container ☐ Other

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

CURRENT WEIGHT: (check one) DATE TAKEN (MM/DD/YY): ☐ (kg) ☐ (lbs.)	Date of current weight must be within 30 days of next injection date to ensure accurate dispensing.	BIRTH WEIGHT: (*check one)* ☐ (kg) ☐ (lbs.)

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

PRESCRIBER'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

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

Diagnosis Code (ICD-9):

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Clinical Data:

Infant/ child's weight: Date recorded:

Please provide anticipated month of start of RSV season in patient's residence area:

What is the ZIP code of the infant's residence if different than above:

Please specify the number of injections you are requesting

- ☐ 3 injections
- ☐ 5 injections
- ☐ Other :

What is the start date of therapy? What is the end date of therapy?

Please note: If you are requesting administration prior to November 1, 2011, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.

Does the patient have any of the following conditions? (Please check all that apply to this patient):

- ☐ Prematurity
- ☐ Chronic Lung Disease
- ☐ Congenital Heart Disease
- ☐ Congenital Abnormalities of the Airway or Neuromuscular disease
- ☐ Severe Immunodeficiency

For patients with Chronic Lung Disease:

Has this patient required any of the following medical care for their Chronic Lung Disease within the last 6 months? (Please check all that apply to this patient):

- ☐ Supplemental oxygen Date of last use:
- ☐ Treatment with a bronchodilator Date of last use:
- ☐ Treatment with a diuretic Date of last use:
- ☐ Treatment with a corticosteroid Date of last use:

For patients with Congenital Heart Disease:

Does this patient have hemodynamically significant heart disease? ☐ Yes ☐ No

Do any of the following conditions apply to this patient? (Please check all that apply to this patient):

- ☐ Receiving medication to control Congestive Heart Failure
- ☐ Have moderate to severe Pulmonary Hypertension
- ☐ Have Cyanotic Congenital Heart Disease

Congenital Abnormalities of the Airway or Neuromuscular disease

Was the infant or child born before 35 weeks gestation? ☐ Yes ☐No

Is there congenital abnormality of the airway? ☐ Yes ☐ No Diagnosis

Is there neuromuscular disease? ☐ Yes ☐ No Diagnosis

Does this condition compromise the handling of respiratory secretions? ☐ Yes ☐ No

For Prematurity:

What was the patient's gestational age at birth in weeks and days? (Please check the gestational age that applies to this patient):

- ☐ 28 weeks or less
- ☐ Between 29 weeks and 32 weeks 0 days
- ☐ Between 32 weeks 1 day and 34 weeks 6 days
- ☐ 35 weeks or more

Does the patient have any of the following risk factors? (Please check all that apply to this patient):

- ☐ Siblings living in their home. If Yes: What is the age of the sibling(s)?
- ☐ Child-care of day-care attendance

Additional pertinent information: