CIGNA Specialty Pharmacy Services
Infertility 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

Fax: 1.800.351.3616
Phone: 1.800.351.3606

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:	DATE OF BIRTH :	NAME:	
ANONYMOUS DONOR MEDICATIONS: Please send in separate forms for patient and anonymous donor medications. ☐ Medications on this form are for the anonymous donor. Anonymous donor number _____		DEA #:	NPI:
HEALTH CARE ID #:	SEX: ☐ M ☐ F	TELEPHONE:	FAX:
HOME PHONE: ALT PHONE: Please provide all available patient phone numbers. This is REQUIRED for scheduling delivery.		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
ADDRESS: (Street) (City) (State) (Zip Code)		**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	
ALLERGIES:		DONOR 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.

*Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No

***FOLLISTIM AQ®** (Follitropin Beta - S0128) ☐ 75 IU Vials	DIRECTIONS:	QTY:	REFILLS:
☐ 150 IU Vials	DIRECTIONS:	QTY:	REFILLS:
☐ 300 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
☐ 600 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
☐ 900 IU Cartridges (automatically send pen device)	DIRECTIONS:	QTY:	REFILLS:
☐ ***GANIRELIX®** 250 mcg Syringe (Ganirelix Acetate - S0132)	DIRECTIONS:	QTY:	REFILLS:
CETROTIDE® (Cetrorelix Acetate - J3490) ☐ 0.25 mg Syringe	DIRECTIONS:	QTY:	REFILLS:
☐ 3 mg Syringe	DIRECTIONS:	QTY:	REFILLS:
☐ **CLOMID®** 50 mg Tablets (Clomiphene Citrate - J3490)	DIRECTIONS:	QTY:	REFILLS:
☐ **CRINONE®** 8% Vaginal Gel (Progesterone - J2675)	DIRECTIONS:	QTY: *Dispensed in boxes of 15 applicators*	REFILLS:
☐ **DOXYCYCLINE TAB** (J3490)_____ mg	DIRECTIONS:	QTY:	REFILLS:
☐ **ENDOMETRIN®** 100mg Vaginal Insert (Progesterone - J3490)	DIRECTIONS:	QTY: **Dispensed in packs of 21 inserts**	REFILLS:
☐ **ESTRACE® TAB** (Estradiol - J3490)_____ mg	DIRECTIONS:	QTY:	REFILLS:
☐ **BRAVELLE®** 75 IU vial (Urofollitropin - J3355)	DIRECTIONS:	QTY:	REFILLS:

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:	HEALTH CARE ID #:	DATE OF BIRTH:

PRESCRIPTION INFORMATION (Continued)

GONAL-F® (Follitropin Alfa – S0126) ☐ RFF 75 IU single-dose syringe	DIRECTIONS:	QTY: REFILLS:
☐ RFF Pen 300 IU/0.5 ml	DIRECTIONS:	QTY: REFILLS:
☐ RFF Pen 450 IU/0.75 ml	DIRECTIONS:	QTY: REFILLS:
☐ RFF Pen 900 IU/1.5 ml	DIRECTIONS:	QTY: REFILLS:
☐ 450 IU multi-dose vial kit	DIRECTIONS:	QTY: REFILLS:
☐ 1050 IU multi-dose vial kit	DIRECTIONS:	QTY: REFILLS:
☐ **HCG (Human Chorionic Gonadotropin)** 10,000 Unit multi-dose vial (J0725) ***see note at bottom of this page***	DIRECTIONS:	QTY: REFILLS:
☐ **LEUPROLIDE** 2 Week Kit (Leuprolide Acetate - J9218)	DIRECTIONS:	QTY: REFILLS:
☐ **LUPRON® MICRODOSE (COMPOUND)** (J3490) Strength: _____ Good for 30 days after it is made, anticipated start date of Lupron Microdose _____	DIRECTIONS:	QTY: (please indicate number of mls to dispense) REFILLS:
☐ **LUVERIS®** 75 IU vial (Lutropin alfa - J3490)	DIRECTIONS:	QTY: REFILLS:
☐ **MEDROL®** (Methylprednisolone - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
☐ **MENOPUR®** 75 IU vial (Menotropins - J3490)	DIRECTIONS:	QTY: REFILLS:
☐ **OVIDREL®** 250mcg pre-filled syringe (Choriogonadotropin Alfa - J3490) ***see note at bottom of this page***	DIRECTIONS:	QTY: REFILLS:
☐ **PREDNISONE® TAB** (Prednisone - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
☐ **PRENATAL PLUS® TABS** (prenatal vitamin with iron - J3490)	DIRECTIONS:	QTY: REFILLS:
☐ **PROGESTERONE VAGINAL SUPPOSITORY (COMPOUND)** (J3490) Strength: _____	DIRECTIONS:	QTY: REFILLS:
☐ **PROGESTERONE IN SESAME OIL** 50 mg/ml vial (J2675)	DIRECTIONS:	QTY: REFILLS:
PROGESTERONE IN OIL (COMPOUND) *Cannot supply in Ethyl oleate ☐ 50mg/ml ☐ 100mg/ml Oil:_____	DIRECTIONS:	QTY: REFILLS:
PROMETRIUM® (Micronized Progesterone - J3490) ☐ 100 mg capsules	DIRECTIONS:	QTY: REFILLS:
☐ 200 mg capsules	DIRECTIONS:	QTY: REFILLS:
☐ **REPRONEX®** 75 IU Vial (Menotropins - S0122)	DIRECTIONS:	QTY: REFILLS:
☐ **VALIUM® TAB** (Diazepam - J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
☐ **VIVELLE® DOT PATCH** _____ mg	DIRECTIONS:	QTY: REFILLS: *Dispensed in boxes of 8 patches*
☐ **ZITHROMAX® TAB** (Azithromycin – J3490) _____ mg	DIRECTIONS:	QTY: REFILLS:
☐ **OTHER** (specify drug name & J-Code)	DIRECTIONS:	QTY: REFILLS:

PATIENT PARTNER PRESCRIPTION INFORMATION

PATIENT PARTNER NAME:	PATIENT PARTNER DATE OF BIRTH:
PATIENT PARTNER ALLERGIES:	PATIENT PARTNER HEALTH CONDITIONS:

☐ **MEDICATION FOR PARTNER** (specify drug name & J-Code)	DIRECTIONS:	QTY: REFILLS:

PRESCRIBER'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

NOTE: we are unable to accept faxed prescriptions for Novarel, Ovidrel, Pregnyl, or any HCG compound from any NY prescriber OR for any NY patient.

**** CIGNA Preferred Status***

(Continued on next page)

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

PRESCRIPTION INFORMATION (Continued)

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

SYRINGES			**NEEDLES**		
☐ 1 cc Syringe (no needle)	QTY:	REFILLS:	☐ 18g 1 1/2" Needles	QTY:	REFILLS:
☐ 1 cc Syringe 27g 1/2"	QTY:	REFILLS:	☐ 22g 1 1/2" Needles	QTY:	REFILLS:
☐ 3 cc Syringe 22g 1"	QTY:	REFILLS:	☐ 23g 1" Needles	QTY:	REFILLS:
☐ 3 cc Syringe 22g 1 ½"	QTY:	REFILLS:	☐ 25g 5/8" Needles	QTY:	REFILLS:
☐ 3 cc Syringe 25g 1"	QTY:	REFILLS:	☐ 25g 1 1/2" Needles	QTY:	REFILLS:
☐ 3 cc Syringe (no needle)	QTY:	REFILLS:	☐ 27g 1/2" Needles	QTY:	REFILLS:
INSULIN SYRINGES			☐ 30g 1/2" Needles	QTY:	REFILLS:
☐ ½ cc 28g ½" (Monoject)	QTY:	REFILLS:	☐ 29g 1/2" Pen Needles	QTY:	REFILLS:
☐ 3/10 cc 30g ½"	QTY:	REFILLS:	☐ **SWABS**	QTY: 100	REFILLS:
☐ ½ cc 30g ½"	QTY:	REFILLS:	☐ **SHARPS CONTAINER**	QTY: 1	REFILLS:
☐ 1 cc 30g ½"	QTY:	REFILLS:			

Answer the following questions on all requests with a diagnosis of female infertility.

What is the patient's diagnosis?
☐ Infertility ☐ Other (*please specify*):

What type of treatment is the patient undergoing? ☐ IUI ☐ IVF ☐ AI ☐ GIFT ☐ ZIFT ☐ Other

What is the anticipated start date of the patient's treatment cycle?

Answer the following question on requests for Gonal-F and Bravelle.

Does the patient have failure, contraindication or intolerance to Follistim AQ? ☐ Yes ☐ No

Please fax completed form to (800)351-3616. View our formulary on line at http://www.cigna.com.

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

****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.