

# CIGNA Specialty Pharmacy Joint Degeneration 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: <span style="float: right;">DEA #:</span>
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.	
ALLERGIES:  <small>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.</small>		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

PRESCRIPTION INFORMATION		
<input type="checkbox"/> <b>EUFLEXXA®</b> (Sodium Hyaluronate – J7323) <input type="checkbox"/> 10 mg/ml (2 ml) Prefilled Syringe	<input type="checkbox"/> <b>HYALGAN®</b> (Sodium Hyaluronate – J7321) <input type="checkbox"/> 10 mg/ml (2 ml) Prefilled Syringe	<input type="checkbox"/> <b>ORTHOVISC®</b> (Sodium Hyaluronate – J7324) <input type="checkbox"/> 15 mg/ml (2 ml) Prefilled Syringe
<input type="checkbox"/> <b>SUPARTZ®</b> (Sodium Hyaluronate – J7321) <input type="checkbox"/> 10 mg/ml (2.5 ml) Prefilled Syringe	<input type="checkbox"/> <b>SYNVISC®</b> (Hylan – J7325) <b>(Typically administered in a series of 3 injections)</b> <input type="checkbox"/> 8 mg/ml (2 ml) Prefilled Syringe	<input type="checkbox"/> <b>SYNVISC-ONE®</b> (Hylan – J7325) <b>(6ml single injection)</b> <input type="checkbox"/> 8 mg/ml (6 ml) Prefilled Syringe
DIRECTIONS:	NUMBER OF INJECTIONS:	REFILLS:
<b>SUPPLIES NEEDED (if medication is to be administered in patient's home):</b> If checked, please specify the size and type (if applicable): <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <input type="checkbox"/> Other		
ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:		
<b>PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:</b>		
<b>MARK THE DIAGNOSIS:</b> <input type="checkbox"/> Degenerative Joint Disease = 715.9 (ICD-9) <input type="checkbox"/> Other (List Diagnosis ICD-9): _____		
DOES THE PATIENT HAVE PAINFUL OSTEOARTHRITIS OF THE KNEE? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WHICH PRIOR ANALGESIC MEDICATIONS (INCLUDING ACETAMINOPHEN, NSAIDs AND COX-II INHIBITORS) HAS THE PATIENT TRIED? PLEASE PROVIDE THE MEDICATION NAME, DOSE, DATES OF USE, AND PLEASE NOTE ANY ADVERSE EFFECTS OF MEDICATIONS.		
DOES THE PATIENT HAVE A CONTRAINDICATION TO ANALGESICS (SUCH AS ACETAMINOPHEN, NSAIDs AND COX-II INHIBITORS)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
IF YES, PLEASE SPECIFY THE CONTRAINDICATION:		
PLEASE NOTE ANY CONSERVATIVE NON-PHARMACOLOGIC THERAPIES TRIED (FOR EXAMPLE, PHYSICAL THERAPY, ETC.):		
ADDITIONAL PERTINENT INFORMATION:		
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