

**CIGNA Tel-Drug Specialty Pharmacy
Joint Degeneration Fax Order Form**



CIGNA Tel-Drug
 Fax: 1.800.351.3616
 Phone: 1.800.351.3606

Please deliver by: _____

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

Order #: _____

PATIENT INFORMATION (Please Print)

Patient Name:		Date:	CIGNA HealthCare ID #:	
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone: () ()		Work Phone: () ()
Address: (Street)		(City)	(State)	(Zip Code)
Allergies:				
Health Conditions:				
Group #:		Member Services Phone: () ()		

PRESCRIPTION INFORMATION

Synvisc: <input type="checkbox"/> 16 mg/2 ml	Sig:	Qty:	Refills:
Hyalgan: <input type="checkbox"/> 20 mg/2 ml	Sig:	Qty:	Refills:
Supartz: <input type="checkbox"/> 25 mg/2.5 ml	Sig:	Qty:	Refills:
Supplies needed: <input type="checkbox"/> Syringes <input type="checkbox"/> Needles <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container <i>If checked, please specify the size and type (if applicable):</i>			
Please include documented progression of disease/prior therapies for justification for the drug:			
Does patient have painful osteoarthritis of the knee? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the patient fail to respond to conservative nonpharmacologic therapy and simple analgesics (acetaminophen, NSAIDs, COXII agents, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List the medications:	Length of therapy:	Dates used:	
Did adverse events or intolerance occur when treated with nonpharmacologic therapy and analgesics? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List the medications:	Associated affects:	Dates:	
Is there a contraindication to conservative nonpharmacologic therapy and simple analgesics? <input type="checkbox"/> Yes <input type="checkbox"/> No			
List these:			
Additional pertinent information:			
Mark the Diagnosis: <input type="checkbox"/> Degenerative Joint Disease = 715.9 (ICD-9) <input type="checkbox"/> Other: _____ (List Diagnosis and ICD-9)			
Prescriber's Printed Name:			
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*

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PHYSICIAN INFORMATION

Name:		DEA #:	
Address: (Street)		(City)	(State) (Zip Code)
Telephone #: ()	Fax #: ()	Ship Medications To: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home	
Home Health Services Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Local Home Health Agency:		Telephone #:
HCPC Information:			HCPC Code: