Hematopoietic Enrollment Form Medications A-D



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 Phone: 1-808-254-2727

NCPDP: 1203417 **Six Simple Steps to Submitting a Referral** PATIENT INFORMATION (Complete or include demographic sheet) Patient Name: Gender: Male Female City, State, ZIP Code: ___ Address: Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: _____ _____Atternate Frione.______Primary Language:________Primary Language:_______ Email: 2 PRESCRIBER INFORMATION State License #: Prescriber's Name: _____ Prescriber's Name: ______ State Lice NPI #: _____ DEA #: _____ Group or Hospital: ____ Address: _____ City, State, ZIP Code: _____ Phone: ____ Fax: ___ Contact Person: ____ Contact's Phone: ____ 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)
4 DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: _____ Ship to: Patient Office Other: _____ Diagnosis (ICD-10): Code: _____ Description: ____ Code: _____ Description: _____
Code: ____ Description: ____ **Patient Clinical Information:** Height: in/cm Weight: lb/kg Allergies: 5 PRESCRIPTION INFORMATION **MEDICATION** STRENGTH **DOSE & DIRECTIONS QUANTITY/REFILLS** Single-dose Vials: ☐ 25 mcg ☐ 40 mcg ☐ 60 mcg ☐ 100 mcg ☐ 150 mcg/.75 mL ☐ 200 mcg ☐ 300 mcg ☐ 500 mcg/1 mL Single-dose Prefilled Syringes: ☐ Inject the entire contents of vial/syringe SC once every other week Quantity: ____ 10 mcg/0.4 mL ☐ Aranesp Inject the entire contents of vial/syringe SC once a week Refills: _____ 25 mcg/0.42 mL Other: ☐ 40 mcg/0.4 mL ☐ 60 mcg/0.3 mL ☐ 100 mcg/0.5 mL ☐ 150 mcg/0.3 mL 200 mcg/0.4 mL ☐ 300 mcg/0.6 mL ☐ 500 mcg/1 mL ☐ Take _ tablet(s) by mouth once daily Quantity: _____ ☐ Take _ tablets by mouth once daily for 5 days beginning Refills: Doptelet 20 mg tablet 10-13 days before procedure Other: _ STAMP SIGNATURE NOT ALLOWED ☐ Patient is interested in patient support programs Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Substitute / Product Selection Permitted /

May Not Substitute Substitution Permissible Prescriber's Signature: _ Prescriber's Signature: _ CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _ ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Hematopoietic Enrollment Form Medications E-Z

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			Patient Phone: scriber Phone:	
	PTION INFORMATION	Pres	ochbei Filohe.	
MEDICATION	STRENGTH	DC	OSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epogen	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	□ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC □ Once a Week □ 3 Times a Week □ Other: □ Multi-dose Vial (MDV): Inject mL (units) SC □ Once a Week □ 3 Times a Week □ Other:		Quantity: Refills:
Fulphila	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every days ☐ Other:		Quantity: Refills:
Leukine	250 mcg vial (lyophilized) 500 mcg/mL vial (liquid)	Administermcg once a day fordays (Circle: IV or SC)		Quantity:
Neulasta	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every days ☐ Other:		Quantity: Refills:
☐ Neumega	5 mg vial kit	Mix and administer 50 ug/kg once a day for days Other:		Quantity:
Neupogen	300 mcg 480 mcg Prefilled Syringe Vial	Administer mcg once a day fordays (Circle: IV or SC) Other:		Quantity: Refills:
Nplate	☐ 125 mcg (SDV) ☐ 250 mcg (SDV) ☐ 500 mcg (SDV)	☐ Inject mcg subcutaneously as one-time dose ☐ Injectmcg subcutaneously once weekly ☐ Other:		Quantity: Refills:
☐ Procrit	2,000 u/mL (SDV) 3,000 u/mL (SDV) 4,000 u/mL (SDV) 10,000 u/mL (SDV) 10,000 u/mL-2 mL vial (MDV) 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: ☐ Multi-dose Vial (MDV): Inject mL (units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other:		Quantity: Refills:
Promacta	12.5 mg tablet 25 mg tablet 50 mg tablet 75 mg tablet 12.5 mg Powder for Oral Suspension 25 mg Powder for Oral Suspension Suspension Suspension Suspension Suspension 12.5 mg Powder for Oral Suspension 13.5 mg Powder for Oral Suspension 14.5 mg Powder for Oral Suspension 14.5 mg Powder for Oral Suspension 14.5 mg Powder for Oral 14.5 mg	Take tablet(s) by mouth once daily Prepare suspension as directed and take packet(s) by mouth once daily Other:		Quantity: Refills:
Udenyca	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every days ☐ Other:		Quantity: _ Refills:
Zarxio	300 mcg Prefilled Syringe 480 mcg Prefilled Syringe	Administer mcg once a day fordays (Circle: IV or SC) Other:		Quantity: Refills:
Patient is interested	d in patient support programs DRESCRIBER SIGNAT	STAMP SIGNATURE NOT	ALLOWED Ancillary supplies and kits pro TAMP SIGNATURE NOT ALLOW	vided as needed for administrat
ense As Written" /	Brand Medically Necessary / Do Not Substit	-	May Substitute / Product Selection Permitted /	
Not Substitute scriber's Signature:		Date:	Substitution Permissible Prescriber's Signature:	Date:

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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