Acromegaly Enrollment Form

CVS specialty®

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

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ _____Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
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: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ E22.0 acromegaly and pituitary giantism ☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Bynfezia Pen (octreotide acetate) injection	2,500 mcg/mL	☐ Administer ____ mcg SC three times a day ☐ Other: _____	☐ 1 pen ☐ 2 pens ☐ Other: _____ Refills: _____
☐ Lanreotide Injection	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe	☐ Inject 90 mg (1 syringe) SC every 4 weeks ☐ Other: Inject _____ mg (1 syringe) SC every 4 weeks	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Sandostatin Injection Ampules	☐ 50 mcg/mL ☐ 100 mcg/mL ☐ 500 mcg/mL	☐ Administer ____ mcg SC three times a day ☐ Other: _____	Quantity: _____ Refills: _____
☐ Sandostatin Injection Multi-dose Vials	☐ 200 mcg/mL (5 ml) ☐ 1,000 mcg/mL (5 ml)	☐ Administer ____ mcg SC three times a day ☐ Other: _____	Quantity: _____ Refills: _____
☐ Sandostatin LAR Depot	☐ 10 mg vial kit ☐ 20 mg vial kit ☐ 30 mg vial kit	☐ Mix the contents of one vial with diluent and administer intragluteally every 4 weeks ☐ Other: _____	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Somatuline Depot	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe	☐ Inject 90 mg (1 syringe) SC every 4 weeks ☐ Other: Inject _____ mg (1 syringe) SC every 4 weeks	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Somavert	☐ 10 mg vial ☐ 15 mg vial ☐ 20 mg vial ☐ 25 mg vial ☐ 30 mg vial	☐ Inject _____mg SC once daily ☐ Other: _____	☐ ___ 10 mg vial kits ☐ ___ 15 mg vial kits ☐ ___ 20 mg vial kits Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____

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.
CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.
Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.
This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.