Specialty Pharmacy Fertility Care Program Enrollment Form

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 CLINICAL INFORMATION

Needs by Date: ______________________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________________
Allergies: ______________________ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cetrotide 0.25 mg Syringe	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Ganirelix 250 mcg/0.5mL	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Leuprolide 2 Week Kit	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Leuprolide Micro Dose ____ mcg / ____ mL	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Follistim AQ 300 IU Cartridge	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Follistim AQ 600 IU Cartridge	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Follistim AQ 900 IU Cartridge	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Follistim Pen	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Gonal-F 450 IU MDV	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Gonal-F 1050 IU MDV	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 300 IU Pen	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 450 IU Pen	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 900 IU Pen	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Menopur 75 IU Vial	☐ Other: ______________	Quantity: _____ Refills: _____
☐ HCG Low Dose ____ Units / ____ mL Vial	☐ Other: ______________	Quantity: _____ Refills: _____
☐ HCG 10,000 Unit Vial	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Novarel 5,000 Unit Vial	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Pregnyl 10,000 Unit Vial	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Ovidrel 250 mcg / 0.5 mL	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Crinone 8% Gel	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Endometrin 100 mg	☐ Other: ______________	Quantity: _____ Refills: _____
☐ Prometrium _______ mg	☐ Other: ______________	Quantity: _____ 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.

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Please Complete Patient and Prescriber Information

Patient Name: ______________________ Patient DOB: ____________ Patient Phone: ____________________

Patient Address: ____

Prescriber Name: ______________________________ Prescriber Phone: ______________________

5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Progesterone Compounded Capsules ____ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Progesterone Suppositories ___ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Progesterone / Sesame Oil 50 mg / mL Vial	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Progesterone(___) 50 mg / mL Vial	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Delestrogen ____ mg / mL	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Syringe 1 mL only	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Syringe 3 mL only	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Syringe 3 mL 18 g 1.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Syringe 3 mL 22 g 1.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 18 g 1.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 22 g 1.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 25 g 1.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 25 g 5/8”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 27 g 0.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Needle 30 g 0.5”	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Insulin Syringe ___ mL	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Aspirin 81 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Azithromycin ____ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Cabergoline 0.5 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Citranatal ___________	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Clomiphene 50 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Dexamethasone ____ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Doxycycline 100 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Estradiol ___ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Folic Acid 1 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Letrozole 2.5 mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Methylprednisolone ____ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Prednisone ____ mg	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Prenatal Plus	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Z-Pak 250 mg #6 Tablets	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Climara 0.1 mg Patch	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Minivelle 0.1 mg Patch	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Vivelle DOT 0.1 mg Patch	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Heparin ____ units / mL Vial	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Lovenox ____ mg Syringes	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Other: ____________	☐ Other: ____________	Quantity: _____ Refills: _____
☐ Other: ____________	☐ Other: ____________	Quantity: _____ Refills: _____

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

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Prescriber’s Signature: ______________ Date: ________	**Prescriber’s Signature: ______________ Date: _______**

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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.
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