Other Gastroenterology 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)

4 DIAGNOSIS AND CLINICAL INFORMATION

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

Diagnosis (ICD-10):

☐ B16.0 Acute Hepatitis B with delta-agent with hepatic coma
☐ B16.1 Acute Hepatitis B with delta-agent without hepatic coma
☐ B16.2 Acute Hepatitis B without delta-agent with hepatic coma
☐ B16.9 Acute Hepatitis B without delta-agent and without hepatic coma
☐ B18.0 Chronic Viral Hepatitis B with delta-agent
☐ B18.1 Chronic Viral Hepatitis B without delta-agent
☐ B19.10 Unspecified Viral Hepatitis B without hepatic coma
☐ B19.11 Unspecified Viral Hepatitis B with hepatic coma
☐ K20.0 Eosinophilic Esophagitis (EoE)
☐ K90.89 Other intestinal malabsorption
☐ K90.9 Intestinal malabsorption, unspecified
☐ R15.9 Full incontinence of feces
☐ Other Code: ____ Description _____

Patient Clinical Information:

Allergies: _____
Weight: _____ lb/kg Height: _____ In/cm TB Test Result: _____ Date: _____

Nursing and Administration:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Adefovir dipivoxil	10 mg tablet	☐ Take one tablet by mouth once daily ☐ Other: _____	Quantity: ☐ 30-day supply ☐ Other: _____ Refills: _____

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

Other Gastroenterology Enrollment Form

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
☐ Baraclude	☐ 0.5 mg tablet ☐ 1 mg tablet ☐ 0.05 mg/mL oral solution	☐ Take one tablet daily on an empty stomach (at least two hours after a meal and two hours before the next meal) ☐ Other: _____	Quantity: ☐ 30-day supply ☐ Other: _____ Refills: _____
☐ Epivir-HBV	☐ 100 mg tablet ☐ 5 mg/mL oral solution	☐ Take one tablet once daily ☐ Other: _____	Quantity: ☐ 30-day supply ☐ Other: _____ Refills: _____
☐ Vemlidy	25 mg tablet	☐ Take one tablet once daily with food ☐ Other: _____	Quantity: ☐ 30-day supply ☐ Other: _____ Refills: _____

5a PRESCRIPTION INFORMATION- EOSINOPHILIC ESOPHAGITIS (EoE)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Dupixent	☐ 200 mg/ 1.14 mL PEN ☐ 200 mg/ 1.14 mL PFS ☐ 300 mg/ 2 mL PEN ☐ 300 mg/ 2 mL PFS	Patients must be ≥ 1 years old and weigh ≥ 15 kg ☐ 15 kg to < 30 kg: Inject 200mg SC every other week ☐ 30 kg to < 40 kg: Inject 300mg SC every other week ☐ > 40 kg: Inject 300mg SC every week	Quantity: ☐ 28-day supply ☐ 84-day supply Refills: _____
☐ Eohilia	2 mg/10 mL	☐ Take 2 mg by mouth twice daily for 12 weeks	Quantity: ☐ 12 week supply Refills: _____

5b PRESCRIPTION INFORMATION- SHORT BOWEL SYNDROME

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Zorbtive	☐ 8.8 mg vial	☐ Inject _____ mL (dose = _____ mg) subcutaneously daily.	Quantity: _____ packages (7 vials per package) Refills: _____

5c PRESCRIPTION INFORMATION- FECAL INCONTINENCE

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Solesta Injectable Gel	4 pre-filled syringes, each containing 1 mL of Solesta + 4 individually wrapped SteriJect needles	☐ Product will be shipped to prescriber's office unless otherwise specified	Quantity: 1 Kit Refills: _____

Other:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ 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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"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ Date: _____

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