Hematopoietics 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. 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 #: _____ Address: _____
City, State, ZIP Code: _____Group or Hospital: _____
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):

☐ Code: _____ Description: _____
☐ Code: _____ Description: _____
☐ Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Height: ____in/cm Weight: ____lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aranesp	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: ☐ 10 mcg/0.4 mL ☐ 25 mcg/0.42 mL ☐ 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	☐ Inject the entire contents of vial/syringe SC once every other week ☐ Inject the entire contents of vial/syringe SC once a week ☐ Other: _____	Quantity: _____ Refills: _____
☐ Doptelet	20 mg tablet	☐ Take __ tablet(s) by mouth once daily ☐ Take __ tablets by mouth once daily for 5 days beginning 10-13 days before procedure ☐ 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.

Hematopoietics Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & 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)	☐ Administer _____mcg once a day for _____days (Circle: IV or SC)	Quantity: _____ Refills: _____
☐ 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: _____ Refills: _____
☐ Neupogen	☐ 300 mcg ☐ 480 mcg ☐ Prefilled Syringe ☐ Vial	☐ Administer _____ mcg once a day for _____days (Circle: IV or SC) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Nplate	☐ 125 mcg (SDV) ☐ 250 mcg (SDV) ☐ 500 mcg (SDV)	☐ Inject __ mcg subcutaneously as one-time dose ☐ Inject __mcg 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	☐ 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 for _____days (Circle: IV or SC) ☐ Other: _____	Quantity: _____ Refills: _____

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