Lupron Depot/Eligard/Zoladex/Firmagon 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/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):

☐ C61 Malignant neoplasm of prostate ☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

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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

Lupron Depot:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Lupron Depot 7.5 mg (1-month supply)	Administer IM once a month	Quantity: 1 kit Refills: _____
☐ Lupron Depot 22.5 mg (3-month supply)	Administer IM once every 3 months	Quantity: 1 kit Refills: _____
☐ Lupron Depot 30 mg (4-month supply)	Administer IM once every 4 months	Quantity: 1 kit Refills: _____
☐ Lupron Depot 45 mg (6-month supply)	Administer IM once every 6 months	Quantity: 1 kit Refills: _____
☐ Leuprolide Acetate Depot 22.5 mg (3-month supply)	Administer IM once every 3 months	Quantity: 1 kit Refills: _____
☐ Other: _____	Other: _____	Quantity: _____ Refills: _____

Eligard:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Eligard 7.5 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: _____
☐ Eligard Depot 22.5 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: _____
☐ Eligard Depot 30 mg (4-month supply)	Administer SC once every 4 months	Quantity: 1 kit Refills: _____
☐ Eligard 45 mg (6-month supply)	Administer SC once every 6 months	Quantity: 1 kit Refills: _____

Zoladex:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Zoladex 3.6 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: _____
☐ Zoladex 10.8 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: _____

Firmagon:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Firmagon 120 mg/vial treatment pack (2 vials)	As an initial dose, administer 240 mg SC as two injections of 120mg each	Quantity: 1 kit Refills: _____
☐ Firmagon 80 mg/vial	Administer 80 mg SC every 28 days	Quantity: 1 kit 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.