Parkinson's 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):

☐ G20 Parkinson's Disease
☐ G20.A1 (Parkinson's disease without dyskinesia, without mention of fluctuations)
☐ G20.A2 (Parkinson's disease without dyskinesia, with fluctuations)
☐ G20.B1 (Parkinson's disease with dyskinesia, without mention of fluctuations)
☐ G20.B2 (Parkinson's disease with dyskinesia, with fluctuations)
☐ G20.C (Parkinsonism, unspecified)
☐ F06.0 Psychotic disorder with hallucinations due to known physiological
☐ F06.2 Psychotic disorder with delusions due to known physiological condition
☐ R44.3 Hallucinations, unspecified
☐ Other Code: _____Description: _____

Patient Clinical Information: Allergies: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Apokyn	**Initial Orders:** • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL). • BD Ultra-Fine pen needles 29G x ½ inch. • Apokyn Pen Paks (each pak includes a single pen device and 6 pen needles). **Additional supplies to be dispensed:** One (1) 1.5-quart sharps container. Two hundred (200) alcohol swabs.	Under medical supervision, inject: ☐ 0.2 mL SC ☐ 0.1 mL SC Titrate on the basis of effectiveness and tolerance, up to a maximum recommended dose of 0.6 mL. Titrate by 0.1 mL as directed by physician, every few days as per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per *"off episode"*	Quantity: • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL) x 10 cartridges. • BD Ultra-Fine pen needles 29G x ½ inch x 100. • Apokyn Pen Paks (each pak includes a single pen device and 6 pen needles) x 2 Refills: 0
☐ Apokyn	**Ongoing Orders:** • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL). • BD Ultra-Fine pen needles 29G x ½ inch. **Additional supplies to be dispensed:** One (1) 1.5-quart sharps container. Two hundred (200) alcohol swabs.	Inject up to _____ mL/dose SC, do not exceed ____ doses per day.	Quantity: **(Select One):** ☐ 30-day supply ☐ 90-day supply ☐ Other: _____ Refills: _____
☐ Duopa	N/A	Please complete a DuoConnect Complete enrollment form and indicate CVS Specialty as your preferred pharmacy provider. (For questions, please contact DuoConnect Complete at 1-844-386-4968).	Quantity: 0 Refills: 0
☐ Nourianz	☐ 20 mg tablet ☐ 40 mg tablet	☐ Take one (1) tablet PO once a day ☐ Other: _____	Quantity: ☐ 30 tablets ☐ Other: _____ Refills: _____
☐ Nuplazid	☐ 34 mg capsule ☐ 10 mg tablet	☐ Take 34 mg (1 capsule) PO once a day ☐ Other: _____	Quantity: ☐ 30 capsules ☐ Other: _____ Refills: _____
☐ Other: _____	Other: _____	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.