Cardiology Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

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):

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

Patient Clinical Information:

Allergies: _____

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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
☐ Arcalyst	NA	Please complete an Arcalyst Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.kiniksaoneconnect.com or by calling 1-833-KINIKSA (1-833-546-4572). Fax enrollment form to 781-609-7826.	Quantity: 0 Refills: 0
☐ Camzyos	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg	☐ Other: _____ Note: Camzyos is only available through a restricted program called the Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program **because of the risk of heart failure due to systolic dysfunction.** Is the patient currently certified in the Camyzos REMS program? ☐ Yes ☐ No Is the prescriber currently certified in the Camyzos REMS program? ☐ Yes ☐ No Please complete the patient status form. The form may be accessed at CAMZYOSREMS.com. Once complete, fax this enrollment form to 888-626-7660.	Quantity: _____ (must be ≤ 35-day supply) Refills:_____
☐ Dofetilide (generic for Tikosyn) ☐ Samsca (tolvaptan) ☐ Tikosyn (dofetilide) ☐ Tolvaptan (generic for Samsca) ☐ Vyndaqel (tafamidis meglumine) ☐ Vyndamax (tafamidis)	☐ Other: _____	☐ Other:_____	Quantity:_____ Refills:_____
RX #1	☐ 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.