Hematopoietic: Hepatitis C 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. 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):

☐ D63.8 Anemia in other chronic diseases classified elsewhere ☐ 285.29 Anemia of other chronic disease
☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

Nursing:

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
☐ 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: _____
☐ 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: _____

☐ 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.

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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
☐ Promacta	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg	☐ _____ mg PO _____ times per day	Quantity: _____ Refills: _____
☐ Retacrit	☐ 2000 u/mL ☐ 3000 u/mL ☐ 4000 u/mL ☐ 10,000 u/mL ☐ 40,000 u/mL	☐ 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: _____

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