

# Hydroxyprogesterone Caproate Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161  
Phone: 1-888-280-1190 OR 787-759-4162  
Email Referral To: Customer.ServiceFax@CVSHealth.com  
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
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: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
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)*

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

- O09.212 supervision of pregnancy with history of preterm labor, second trimester  
 O09.213 supervision of pregnancy with history of preterm labor, third trimester  
 O09.219 supervision of pregnancy with history of preterm labor, unspecified trimester  
 Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Hydroxyprogesterone Caproate <input type="checkbox"/> 1 mL vial	250 mg/mL	250 mg administered IM once weekly (every 7 days)	Quantity: _____ <input type="checkbox"/> 4 vial (28-day supply) Refills: _____
<input type="checkbox"/> 3 mL 18 g 1.5" Syringe	Other: _____	Use as directed to withdraw Hydroxyprogesterone Caproate	Quantity: _____ Refills: _____
<input type="checkbox"/> 22 g 1.5" Needle	Other: _____	Use as directed to inject Hydroxyprogesterone Caproate	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: \_\_\_\_\_

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

### 6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_

X \_\_\_\_\_

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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