# Retinal Disorders/Ocular Specialty Enrollment Form

CVS specialty®

**Fax Referral To:** 1-877-232-5455
**Address:** 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

**Phone:** 1-800-896-1464

## Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
**Relationship to minor**: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

### 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)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

**Diagnosis (ICD-10):**
ICD-10 Code: _____ Diagnosis: _____ Affected eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes

**Patient Clinical Information:**
Allergies: _____ Height: _____in/cm Weight: _____lb./kg

**Durysta**: Can only be used once per lifetime per eye.
Has the patient received a prior **Durysta** implant in the treatment eye? ☐ Yes ☐ No

**Iluvien**:
Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:
Medication prescribed _____ Date prescribed _____

**Susvimo**:
Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo:**
Medication prescribed _____ Date prescribed _____
Medication prescribed _____ Date prescribed _____

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# Retinal Disorders/Ocular Specialty Enrollment Form

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Beovu | ☐ Vial<br>☐ PFS | **Induction dose:**<br>☐ Inject 6 mg monthly for the first three doses<br>☐ Inject 6 mg every 6 weeks for the first five doses<br>☐ Other: _____<br>**Maintenance dose:**<br>☐ Inject 6 mg every 8 to 12 weeks<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Byooviz | ☐ 0.5mg single-dose vial | ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Durysta | 1 applicator | ☐ To be injected by physician as directed<br>☐ Other: _____ | Quantity: _____ |
| ☐ Eylea | ☐ Vial<br>☐ PFS | ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks<br>☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment<br>☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks<br>☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Iluvien | 1 applicator | ☐ To be injected by physician as directed<br>☐ Other: _____ | Quantity: _____ |
| ☐ Lucentis | ☐ 0.3 mg/0.05 mL single-dose PFS<br>☐ 0.3 mg/0.05 mL single-dose vial<br>☐ 0.5 mg/0.05 mL single-dose PFS<br>☐ 0.5 mg/0.05 mL single-dose vial | ☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br>☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Ozurdex | 1 applicator | ☐ To be injected by physician as directed<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Retisert | 1 implant | ☐ To be implanted by physician as directed<br>☐ Other: _____ | Quantity: _____ |
| ☐ Susvimo | 1 implant | ☐ To be implanted by physician as directed<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Vabysmo | 6 mg | ☐ To be injected by physician as directed<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Visudyne | Vial | ☐ To be infused by physician as directed<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Other: | Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Yutiq | 0.18 mg (single dose implant) | ☐ To be injected by physician as directed<br>☐ Other: _____ | Quantity: _____<br>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<br>**Prescriber's Signature: _____ Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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