

Retinal Disorders/Ocular Specialty 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 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: _____ 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 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 _____

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Please complete Patient and Prescriber information

Patient Name: _____

Patient DOB: _____

Prescriber Name: _____

Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Beovu	Vial	Induction dose: <input type="checkbox"/> Inject 6 mg monthly for the first three doses <input type="checkbox"/> Other: _____ Maintenance dose: <input type="checkbox"/> Inject 6 mg every 8 to 12 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Durysta	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Eylea	<input type="checkbox"/> Vial <input type="checkbox"/> PFS	<input type="checkbox"/> 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 <input type="checkbox"/> Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment <input type="checkbox"/> 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 <input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Iluvien	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Lucentis	<input type="checkbox"/> 0.3mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.3mg/0.05 mL single-dose vial <input type="checkbox"/> 0.5mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.5mg/0.05 mL single-dose vial	<input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ozurdex	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Retisert	1 implant	<input type="checkbox"/> To be implanted by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Visudyne	Vial	<input type="checkbox"/> To be infused by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yutiq	0.18mg (single dose implant)	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> 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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