

Acromegaly Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: customerservicefax@caremark.com

Phone: 1-800-237-2767

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):

☐ E22.0 acromegaly and pituitary giantism ☐ Other Code: _____ Description: _____

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us)

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Patient Clinical Information:

Allergies: _____

Height: _____ in/cm

Weight: _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Bynfezia Pen (octreotide acetate) injection	2,500 mcg/mL	<input type="checkbox"/> Administer _____ mcg SC three times a day <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1 pen <input type="checkbox"/> 2 pens Refills: _____
<input type="checkbox"/> Sandostatin Injection Ampules	<input type="checkbox"/> 50 mcg/ml <input type="checkbox"/> 100 mcg/ml <input type="checkbox"/> 500 mcg/ml	<input type="checkbox"/> Administer _____ mcg SC three times a day <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Sandostatin Injection Multi-dose Vials	<input type="checkbox"/> 200 mcg/ml (5 ml) <input type="checkbox"/> 1,000 mcg/ml (5 ml)	<input type="checkbox"/> Administer _____ mcg SC three times a day <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Sandostatin LAR Depot	<input type="checkbox"/> 10 mg vial kit <input type="checkbox"/> 20 mg vial kit <input type="checkbox"/> 30 mg vial kit	<input type="checkbox"/> Mix the contents of one vial with diluent and administer intragluteally every 4 weeks <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Somatuline Depot	<input type="checkbox"/> 60 mg prefilled syringe <input type="checkbox"/> 90 mg prefilled syringe <input type="checkbox"/> 120 mg prefilled syringe	<input type="checkbox"/> Inject 90 mg (1 syringe) SC every 4 weeks <input type="checkbox"/> Other: Inject _____ mg (1 syringe) SC every 4 weeks	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Somavert	<input type="checkbox"/> 10 mg vial <input type="checkbox"/> 15 mg vial <input type="checkbox"/> 20 mg vial <input type="checkbox"/> 25 mg vial <input type="checkbox"/> 30 mg vial	<input type="checkbox"/> Inject _____ mg SC once daily <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> _____ 10 mg vial kits <input type="checkbox"/> _____ 15 mg vial kits <input type="checkbox"/> _____ 20 mg vial kits Refills: _____

☐ 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 below, 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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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