Acromegaly Enrollment Form

CVS specialty™

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

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

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

DISPENSE AS WRITTEN (Date)
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.