Amyloidosis Enrollment Form

CVS specialty®

Fax Referral To: 1-855-592-6890 **Phone:** 1-866-526-4984

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
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. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

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

Diagnosis (ICD-10):

☐ E85.1 Neuropathic heredofamilial amyloidosis (transthyretin-related [ATTR] familial amyloid polyneuropathy)
☐ E85.82 Wild-type transthyretin-related (ATTR) amyloidosis (transthyretin-related [ATTR] wild-type amyloid cardiomyopathy)
☐ Other Code: _____Description: _____

Patient Clinical Information:

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

Nursing:

Specialty Pharmacy to coordinate home health nursing? ☐ Yes ☐ No
Site of Care: ☐ Physician office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health ☐ Other
Anticipated first treatment date: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Onpattro (patisiran)	10 mg/5 mL vial	Infuse _____ mg (0.3 mg/kg) intravenously in normal saline (for total volume of 200 mL) over approximately 80 minutes every 3 weeks as directed. Patient weight: _____ kg	Quantity: _____ vials Refills: ☐ 12 months ☐ __months
☐ Amvuttra (vutrisiran)	25 mg/0.5 mL prefilled syringe	Inject 25 mg via subcutaneous injection once every 3 months. To be administered by a healthcare professional.	Quantity: #1 Refills: ☐ x 3 ☐ Other: ____ refills
☐ Vyndamax (tafamidis)	61 mg capsules	Take 1 capsule by mouth daily.	Quantity: ___ capsules Refills: _____
☐ Vyndaqel (tafamidis meglumine)	20 mg capsules	Take 4 capsules by mouth daily.	Quantity: ___ capsules Refills: _____

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
☐ Epinephrine **nursing requires**	☐ IM	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed

☐ 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 **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **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.