

Food Allergy Enrollment Form



Fax Referral To: 1-800-323-2445 Phone: 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com



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 medical 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):

Z91.010 Allergy to peanuts Z91.013 Allergy to seafood Z91.012 Allergy to eggs

Z91.011 Allergy to milk products Z91.018 Allergy to other foods

Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Height: _____ in/cm Weight: _____ lb/kg

Clinical history consistent with IgE-mediated response

Positive specific IgE and/or positive skin prick test and/or oral food challenges to allergenic food(s)

Pretreatment serum IgE level IU/ml: _____

Prescription Type: Naïve/new start Restart Last received date if applicable _____

Place of Administration Physician's Office Alternate injection center Patient's address

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Please Complete Patient and Prescriber Information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Xolair	<p>Vial</p> <input type="checkbox"/> 150 mg vial kit	<p>Every 4 weeks dosing:</p> <input type="checkbox"/> Administer 75 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 150 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 4 weeks	<p>Quantity:</p> _____ vials <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ____-day supply
	<p>PFS</p> <input type="checkbox"/> 75 mg/0.5 mL pre-filled syringe <input type="checkbox"/> 150 mg/1 mL pre-filled syringe <input type="checkbox"/> 300 mg/2 mL pre-filled syringe	<p>Every 2 weeks dosing:</p> <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 375 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 2 weeks	<p>Refills:</p> <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
	<p>Auto-injector</p> <input type="checkbox"/> 75 mg/0.5 mL <input type="checkbox"/> 150 mg/mL <input type="checkbox"/> 300 mg/2 mL	<p>For Xolair Vials only:</p> <input type="checkbox"/> No supplies requested (supplies will be sent with shipment unless indicated) <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply <ul style="list-style-type: none"> One 10 mL vial sterile water for injection for every vial of Xolair dispensed Alcohol swabs Flexible bandages 1" x 3" 3 mL Luer Lock injection syringe NDL 18G x 1½" Safety Glide needle for reconstitution NDL 25G x ⅝" Safety Glide needle for subcutaneous injection 	

Patient is interested in patient support programs

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.

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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