Hematopoietics Enrollment Form

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

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. 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 #: __________ Address: ____________________
City, State, ZIP Code: ____________________ Group or Hospital: ____________________
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):

☐ Code: __________ Description: ____________________
☐ Code: __________ Description: ____________________
☐ Code: __________ Description: ____________________

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aranesp	Single-dose Vials: ☐ 25 mcg ☐ 40 mcg ☐ 60 mcg ☐ 100 mcg ☐ 150 mcg/.75 mL ☐ 200 mcg ☐ 300 mcg ☐ 500 mcg/1 mL Single-dose Prefilled Syringes: ☐ 10 mcg/0.4 mL ☐ 25 mcg/0.42 mL ☐ 40 mcg/0.4 mL ☐ 60 mcg/0.3 mL ☐ 100 mcg/0.5 mL ☐ 150 mcg/0.3 mL ☐ 200 mcg/0.4 mL ☐ 300 mcg/0.6 mL ☐ 500 mcg/1 mL	☐ Inject the entire contents of vial/syringe SC once every other week ☐ Inject the entire contents of vial/syringe SC once a week ☐ Other: ____________________	Quantity: ________ Refills: __________
☐ Doptelet	20 mg tablet	☐ Take __ tablet(s) by mouth once daily ☐ Take __ tablets by mouth once daily for 5 days beginning 10-13 days before procedure ☐ Other: ____________________	Quantity: ________ Refills: __________

☐ 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.

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Please Complete Patient and Prescriber Information

Patient Name: ____________________ Patient DOB: ____________________

Patient Address: ____

Prescriber Name: ____________________ Prescriber Phone: ____________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epogen	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________ ☐ Multi-dose Vial (MDV): Inject ________ mL (_______units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________	Quantity: ________ Refills: ________
☐ Fulphila	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every _______ days ☐ Other: __________	Quantity: ________ Refills: ________
☐ Leukine	☐ 250 mcg vial (lyophilized) ☐ 500 mcg/mL vial (liquid)	☐ Administer _____mcg once a day for _____days (Circle: IV or SC)	Quantity: ________ Refills: ________
☐ Neulasta	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every _____ days ☐ Other: __________	Quantity: ________ Refills: ________
☐ Neumega	5 mg vial kit	☐ Mix and administer 50 ug/kg once a day for ______ days ☐ Other: __________	Quantity: ________ Refills: ________
☐ Neupogen	☐ 300 mcg ☐ 480 mcg ☐ Prefilled Syringe ☐ Vial	☐ Administer _____ mcg once a day for _____days (Circle: IV or SC) ☐ Other: __________	Quantity: ________ Refills: ________
☐ Nplate	☐ 125 mcg (SDV) ☐ 250 mcg (SDV) ☐ 500 mcg (SDV)	☐ Inject __ mcg subcutaneously as one-time dose ☐ Inject __mcg subcutaneously once weekly ☐ Other: __________	Quantity: ________ Refills: ________
☐ Procrit	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________ ☐ Multi-dose Vial (MDV): Inject ________ mL (_______units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________	Quantity: ________ Refills: ________
☐ Promacta	☐ 12.5 mg tablet ☐ 25 mg tablet ☐ 50 mg tablet ☐ 75 mg tablet ☐ 12.5 mg Powder for Oral Suspension ☐ 25 mg Powder for Oral Suspension	☐ Take __ tablet(s) by mouth once daily ☐ Prepare suspension as directed and take __ packet(s) by mouth once daily ☐ Other: __________	Quantity: ________ Refills: ________
☐ Udenyca	6 mg Prefilled Syringe	☐ Inject 6 mg SC day after chemotherapy, every _____ days ☐ Other: __________	Quantity: ________ Refills: ________
☐ Zarxio	☐ 300 mcg Prefilled Syringe ☐ 480 mcg Prefilled Syringe	☐ Administer _____ mcg once a day for _____days (Circle: IV or SC) ☐ Other: __________	Quantity: ________ Refills: ________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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