Parkinson's 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. 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):

☐ G20 Parkinson's Disease
☐ G20.A1 (Parkinson's disease without dyskinesia, without mention of fluctuations)
☐ G20.A2 (Parkinson's disease without dyskinesia, with fluctuations)
☐ G20.B1 (Parkinson's disease with dyskinesia, without mention of fluctuations)
☐ G20.B2 (Parkinson's disease with dyskinesia, with fluctuations)
☐ G20.C (Parkinsonism, unspecified)
☐ F06.0 Psychotic disorder with hallucinations due to known physiological
☐ F06.2 Psychotic disorder with delusions due to known physiological condition
☐ R44.3 Hallucinations, unspecified
☐ Other Code: ________ Description: ______________________________

Patient Clinical Information: Allergies: ____

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Parkinson’s Enrollment Form

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
☐ Apokyn	**Initial Orders:** • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL). • BD Ultra-Fine pen needles 29G x ½ inch. • Apokyn Pen Paks (each pak includes a single pen device and 6 pen needles). **Additional supplies to be dispensed:** One (1) 1.5-quart sharps container. Two hundred (200) alcohol swabs.	Under medical supervision, inject: ☐ 0.2 mL SC ☐ 0.1 mL SC Titrate on the basis of effectiveness and tolerance, up to a maximum recommended dose of 0.6 mL. Titrate by 0.1 mL as directed by physician, every few days as per patient response until patient reaches maximum tolerated dose or to a max dose of 0.6 mL per *“off episode”*	Quantity: • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL) x 10 cartridges. • BD Ultra-Fine pen needles 29G x ½ inch x 100. • Apokyn Pen Paks (each pak includes a single pen device and 6 pen needles) x 2 Refills: 0
☐ Apokyn	**Ongoing Orders:** • Apomorphine hydrochloride injection 30 mg/3 mL (10 mg/mL). • BD Ultra-Fine pen needles 29G x ½ inch. **Additional supplies to be dispensed:** One (1) 1.5-quart sharps container. Two hundred (200) alcohol swabs.	Inject up to ______ mL/dose SC, do not exceed ____ doses per day.	Quantity: **(Select One):** ☐ 30-day supply ☐ 90-day supply ☐ Other: ______________ Refills: _________________
☐ Duopa	N/A	Please complete a DuoConnect Complete enrollment form and indicate CVS Specialty as your preferred pharmacy provider. (For questions, please contact DuoConnect Complete at 1-844-386-4968).	Quantity: 0 Refills: 0
☐ Nourianz	☐ 20 mg tablet ☐ 40 mg tablet	☐ Take one (1) tablet PO once a day ☐ Other: ______________________________	Quantity: ☐ 30 tablets ☐ Other: ______________ Refills: _________________
☐ Nuplazid	☐ 34 mg capsule ☐ 10 mg tablet	☐ Take 34 mg (1 capsule) PO once a day ☐ Other: ________________________	Quantity: ☐ 30 capsules ☐ Other: _______________ Refills: _________________
☐ Other: ___________	Other: ___________________________	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.

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.
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