Transplant Enrollment Form

CVS specialty®

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):

☐ Z94.0 Kidney Transplant Status ☐ Z94.1 Heart Transplant Status ☐ Z94.2 Lung Transplant Status
☐ Z94.3 Heart and Lung Transplant Status ☐ Z94.4 Liver Transplant Status ☐ Z94.5 Skin Transplant Status
☐ Z94.6 Bone Transplant Status ☐ Z94.7 Corneal Transplant Status ☐ Z94.81 Bone Marrow Transplant Status
☐ Z94.82 Intestine Transplant Status ☐ Z94.83 Pancreas Transplant Status ☐ Z94.84 Stem Cells Transplant Status
☐ Other Code: _____ Description _____

Required Information for Organ Transplant Patients:

Patient Medicare status (check all that apply):
☐ Had Medicare at time of transplant ☐ Currently has Medicare ☐ Does not have Medicare
If patient has Medicare, please provide Medicare ID: _____
Date of Transplant: _____ Discharge Date: _____
Hospital Name, City and State: _____
For Kidney Transplant: Initial Dialysis Date _____ Type of Dialysis ☐ Hemo ☐ Peritoneal

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION (DIABETIC SUPPLIES)

☐ Not a Diabetic
☐ Insulin ☐ Non-Insulin Diagnosis Code: _____
Glucometer: _____
Test Strips: _____
Lancets: _____
0.5 cc Insulin Syringes: _____
Short Acting Insulin: _____
Long-Acting Insulin: _____
☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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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 (IMMUNOSUPPRESSANTS)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Astagraf XL	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: _____	Quantity: _____ Refills: ___
☐ Azasan	☐ 75 mg ☐ 100 mg	Other: _____	Quantity: _____ Refills: ___
☐ Cellcept	☐ 250 mg ☐ 500 mg ☐ 200 mg/mL	Other: _____	Quantity: _____ Refills: ___
☐ Envarsus XR	☐ 0.75 mg ☐ 1 mg ☐ 4 mg	Other: _____	Quantity: _____ Refills: ___
☐ Gengraf	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	Quantity: _____ Refills: ___
☐ Imuran	50 mg	Other: _____	Quantity: _____ Refills: ___
☐ Myfortic	☐ 180 mg ☐ 360 mg	Other: _____	Quantity: _____ Refills: ___
☐ Neoral	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	Quantity: _____ Refills: ___
☐ Nulojix	250 mg vial	Other: _____	Quantity: _____ Refills: ___
☐ Prednisone	☐ 5 mg ☐ 10 mg	Other: _____	Quantity: _____ Refills: ___
☐ Prograf	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: _____	Quantity: _____ Refills: ___
☐ Rapamune	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/mL	Other: _____	Quantity: _____ Refills: ___
☐ Sandimmune	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: _____	Quantity: _____ Refills: ___
☐ Zortress	☐ 0.25 mg ☐ 0.50 mg ☐ 0.75 mg	Other: _____	Quantity: _____ Refills: ___

5 PRESCRIPTION INFORMATION (OTHER)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ PCP Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ PCP Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ CMV Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ CMV Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Thrush (Candida): _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Hematopoietics: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Hematopoietics: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: ___
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ 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.