

Wilson's Disease 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: _____

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: _____ DOB: _____

Gender: Male Female Email: _____

Last Four of SSN: _____ Primary Language: _____

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)

4 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

E83.0 Disorders of Copper Metabolism H18.0 Corneal Pigmentation and Deposits E72.01 Cystinuria

Other Code: _____ Description: _____

Patient Clinical Information:

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

First time receiving Wilson's Disease therapy? Yes No

If No, previous product used: _____

Documented reactions to Wilson's Disease therapy: _____

Wilson's Disease Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____

Patient DOB: _____

Prescriber Name: _____

Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cuprimine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Depen (Titratable Tablets)	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Penicillamine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Penicillamine (Titratable Tablets)	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Syprine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Trientine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____

X _____

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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