

# Other Gastroenterology 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)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_

Ship to:  Patient  Office  Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

- B16.0 Acute Hepatitis B with delta-agent with hepatic coma
- B16.1 Acute Hepatitis B with delta-agent without hepatic coma
- B16.2 Acute Hepatitis B without delta-agent with hepatic coma
- B16.9 Acute Hepatitis B without delta-agent and without hepatic coma
- B18.0 Chronic Viral Hepatitis B with delta-agent
- B18.1 Chronic Viral Hepatitis B without delta-agent
- B19.10 Unspecified Viral Hepatitis B without hepatic coma
- B19.11 Unspecified Viral Hepatitis B with hepatic coma
- K20.0 Eosinophilic Esophagitis (EoE)
- K90.89 Other intestinal malabsorption
- K90.9 Intestinal malabsorption, unspecified
- R15.9 Full incontinence of feces
- Other Code: \_\_\_\_ Description \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ In/cm TB Test Result: \_\_\_\_\_ Date: \_\_\_\_\_

#### Nursing and Administration:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary?  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Health

Injection training not necessary. Date training occurred: \_\_\_\_\_

Reason:  MD office training patient  Pt already independent  Referred by MD to alternate trainer

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Adefovir dipivoxil	10 mg tablet	<input type="checkbox"/> Take one tablet by mouth once daily <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____ Refills: _____

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

<p><small>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</small></p> <p><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____</p>	<p><small>May Substitute / Product Selection Permitted / Substitution Permissible</small></p> <p><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____</p>
<p><b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription</p>	

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

# Other Gastroenterology Enrollment Form

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Baraclude	<input type="checkbox"/> 0.5 mg tablet <input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 0.05 mg/mL oral solution	<input type="checkbox"/> Take one tablet daily on an empty stomach (at least two hours after a meal and two hours before the next meal) <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Epivir-HBV	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 5 mg/mL oral solution	<input type="checkbox"/> Take one tablet once daily <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Vemlidy	25 mg tablet	<input type="checkbox"/> Take one tablet once daily with food <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____ Refills: _____

### 5a PRESCRIPTION INFORMATION- EOSINOPHILIC ESOPHAGITIS (EoE)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200 mg/ 1.14 mL PEN <input type="checkbox"/> 200 mg/ 1.14 mL PFS <input type="checkbox"/> 300 mg/ 2 mL PEN <input type="checkbox"/> 300 mg/ 2 mL PFS	Patients must be $\geq 1$ years old and weigh $\geq 15$ kg <input type="checkbox"/> 15 kg to < 30 kg: Inject 200mg SC every other week <input type="checkbox"/> 30 kg to < 40 kg: Inject 300mg SC every other week <input type="checkbox"/> > 40 kg: Inject 300mg SC every week	Quantity: _____ <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply Refills: _____
<input type="checkbox"/> Eohilia	2 mg/10 mL	<input type="checkbox"/> Take 2 mg by mouth twice daily for 12 weeks	Quantity: _____ <input type="checkbox"/> 12 week supply Refills: _____

### 5b PRESCRIPTION INFORMATION- SHORT BOWEL SYNDROME

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Zorbtive	<input type="checkbox"/> 8.8 mg vial	<input type="checkbox"/> Inject _____ mL (dose = _____ mg) subcutaneously daily.	Quantity: _____ packages (7 vials per package) Refills: _____

### 5c PRESCRIPTION INFORMATION- FECAL INCONTINENCE

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Solesta Injectable Gel	4 pre-filled syringes, each containing 1 mL of Solesta + 4 individually wrapped SteriJect needles	<input type="checkbox"/> Product will be shipped to prescriber's office unless otherwise specified	Quantity: 1 Kit Refills: _____

Other: \_\_\_\_\_

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Other:	<input type="checkbox"/> _____	<input type="checkbox"/> _____	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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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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