Hematopoietics Enrollment Form

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Fax Referral To: 1-855-297-1270 Address: 6020 Ave Boberto Sanchez Vilella Carolina, PB 00982

Phone: 1-888-280-1190

		Address: 6020 Ave Roberto	o Sanchez Vilella Ca	irolina, PR 00982	NCPDP: 4026325	
		Six Simple Steps to Sub	omittin <u>g a Referr</u>	al		
ATIENT INFO	DRMATION (Complete or inclu					
			DOB:	Gender: 🗌 Ma	le 🗌 Female	
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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.

Hematopoietics Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name:

Patient Address: ___ Prescriber Name: _ Patient DOB: __

Prescriber Phone: _____

5 PRESCRI	PTION INFORMATION			
MEDICATION	STRENGTH	DO	SE & 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 Once a Week 3 Tir Multi-dose Vial (MDV) Once a Week 3 Tir	Quantity: Refills:	
🗌 Fulphila	mg Prefilled Syringe			Quantity: Refills:
Leukine	250 mcg vial (lyophilized) 500 mcg/mL vial (liquid)	Administermcg (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	Quantity: Refills:	
🗌 Neupogen	☐ 300 mcg ☐ 480 mcg ☐ Prefilled Syringe ☐ Vial	Administer mcg (Circle: IV or SC) Other:	Quantity: Refills:	
Nplate	☐ 125 mcg (SDV) ☐ 250 mcg (SDV) ☐ 500 mcg (SDV)	Inject mcg subcutar Injectmcg subcutan 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 Once a Week 3 Tir Multi-dose Vial (MDV) Once a Week 3 Tir	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 fordays (Circle: IV or SC) Other:		Quantity: Refills:
Patient is interested	d in patient support programs 6 PRESCRIBER SIGNAT	STAMP SIGNATURE NOT A URE REQUIRED (S1	ALLOWED Ancillary supplies and kits pro FAMP SIGNATURE NOT ALLOW	vided as needed for administrati (ED)
DAW / May Not Su	ten" / Brand Medically Necessary / Do Not St	ubstitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:

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 sub mit 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. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _

___ ATTN: New York and Iowa providers, please submit electronic prescription