

# Hematopoietic: Hepatitis C Enrollment Form



Fax Referral To: 1-877-232-5455  
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727  
NCPDP: 1203417

## 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. 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 #: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State, ZIP Code: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_  
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):

D63.8 Anemia in other chronic diseases classified elsewhere  285.29 Anemia of other chronic disease  
 Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

#### Nursing:

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"/> Epogen	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Procrit	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> 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: _____
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**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.

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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

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Promacta	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/> _____ mg PO _____ times per day	Quantity: _____ Refills: _____
<input type="checkbox"/> Retacrit	<input type="checkbox"/> 2000 u/mL <input type="checkbox"/> 3000 u/mL <input type="checkbox"/> 4000 u/mL <input type="checkbox"/> 10,000 u/mL <input type="checkbox"/> 40,000 u/mL	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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