



Procrit 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. 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):
 D63.0 Anemia in neoplastic disease D63.1 Anemia in chronic kidney disease
 D63.8 Anemia in other chronic diseases classified elsewhere D64.81 Anemia due to antineoplastic chemotherapy
 D64.9 Anemia unspecified Other Code: _____ Description: _____

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Procrit epoetin alfa	<input type="checkbox"/> 2,000 units/mL (single-dose vial) <input type="checkbox"/> 3,000 units/mL (single-dose vial) <input type="checkbox"/> 4,000 units/mL (single-dose vial) <input type="checkbox"/> 10,000 units/mL (single-dose vial) <input type="checkbox"/> 10,000 units/mL – 2 mL vial (multi-dose vial) <input type="checkbox"/> 20,000 units/mL – 1 mL vial (multi-dose vial) <input type="checkbox"/> 40,000 units/mL (single-dose vial)	<input type="checkbox"/> Single-dose Vial: 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: Inject _____ mL (_____ units) SC. <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Include 25G 5/8" syringes, alcohol pads, and sharps container – free of charge	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.

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.