Transplant 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):

☐ Z94.0 Kidney Transplant Status
☐ Z94.1 Heart Transplant Status
☐ Z94.2 Lung Transplant Status
☐ Z94.3 Heart and Lung Transplant Status
☐ Z94.4 Liver Transplant Status
☐ Z94.5 Skin Transplant Status
☐ Z94.6 Bone Transplant Status
☐ Z94.7 Corneal Transplant Status
☐ Z94.81 Bone Marrow Transplant Status
☐ Z94.82 Intestine Transplant Status
☐ Z94.83 Pancreas Transplant Status
☐ Z94.84 Stem Cells Transplant Status
☐ Other Code: ______ Description ______________________

Required Information for Organ Transplant Patients:

Patient Medicare status (check all that apply):
☐ Had Medicare at time of transplant ☐ Currently has Medicare ☐ Does not have Medicare
If patient has Medicare, please provide Medicare ID: ____________
Date of Transplant: ____________ Discharge Date: ____________
Hospital Name, City and State: ______________________
For Kidney Transplant: Initial Dialysis Date____________ Type of Dialysis ☐ Hemo ☐ Peritoneal

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION (DIABETIC SUPPLIES)

☐ Not a Diabetic
☐ Insulin ☐ Non-Insulin Diagnosis Code: ________
Glucometer: ______________________
Test Strips: ______________________
Lancets: ______________________
0.5 cc Insulin Syringes: ______________________
Short Acting Insulin: ______________________
Long-Acting Insulin: ______________________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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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 (IMMUNOSUPPRESSANTS)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Astagraf XL	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Azasan	☐ 75 mg ☐ 100 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Cellcept	☐ 250 mg ☐ 500 mg ☐ 200 mg/mL	Other: ________________	Quantity: _____ Refills: ___
☐ Envarsus XR	☐ 0.75 mg ☐ 1 mg ☐ 4 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Gengraf	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: ________________	Quantity: _____ Refills: ___
☐ Imuran	50 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Myfortic	☐ 180 mg ☐ 360 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Neoral	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: ________________	Quantity: _____ Refills: ___
☐ Nulojix	250 mg vial	Other: ________________	Quantity: _____ Refills: ___
☐ Prednisone	☐ 5 mg ☐ 10 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Prograf	☐ 0.5 mg ☐ 1 mg ☐ 5 mg	Other: ________________	Quantity: _____ Refills: ___
☐ Rapamune	☐ 0.5 mg ☐ 1 mg ☐ 2 mg ☐ 1 mg/mL	Other: ________________	Quantity: _____ Refills: ___
☐ Sandimmune	☐ 25 mg ☐ 100 mg ☐ 100 mg/mL	Other: ________________	Quantity: _____ Refills: ___
☐ Zortress	☐ 0.25 mg ☐ 0.50 mg ☐ 0.75 mg	Other: ________________	Quantity: _____ Refills: ___

5 PRESCRIPTION INFORMATION (OTHER)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ PCP Prophylaxis: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ PCP Prophylaxis: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ CMV Prophylaxis: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ CMV Prophylaxis: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Thrush (Candida): ________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Hematopoietics: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Hematopoietics: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Gastrointestinal: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Gastrointestinal: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Gastrointestinal: _________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	Other: ___________________________________	Quantity: _____ Refills: ___
☐ Other: _________________	Other: _____	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:** ______

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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