

# Acromegaly Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

## 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):

E22.0 acromegaly and pituitary giantism

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

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

Height: \_\_\_\_\_ in/cm

Weight: \_\_\_\_\_ lb/kg

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Bynfezia Pen (octreotide acetate) injection	2,500 mcg/mL	<input type="checkbox"/> Administer ____ mcg SC three times a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 pen <input type="checkbox"/> 2 pens <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Lanreotide Injection	<input type="checkbox"/> 60 mg prefilled syringe <input type="checkbox"/> 90 mg prefilled syringe <input type="checkbox"/> 120 mg prefilled syringe	<input type="checkbox"/> Inject 90 mg (1 syringe) SC every 4 weeks <input type="checkbox"/> Other: Inject _____ mg (1 syringe) SC every 4 weeks	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Sandostatin Injection Ampules	<input type="checkbox"/> 50 mcg/mL <input type="checkbox"/> 100 mcg/mL <input type="checkbox"/> 500 mcg/mL	<input type="checkbox"/> Administer ____ mcg SC three times a day <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Sandostatin Injection Multi-dose Vials	<input type="checkbox"/> 200 mcg/mL (5 ml) <input type="checkbox"/> 1,000 mcg/mL (5 ml)	<input type="checkbox"/> Administer ____ mcg SC three times a day <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Sandostatin LAR Depot	<input type="checkbox"/> 10 mg vial kit <input type="checkbox"/> 20 mg vial kit <input type="checkbox"/> 30 mg vial kit	<input type="checkbox"/> Mix the contents of one vial with diluent and administer intragluteally every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Somatuline Depot	<input type="checkbox"/> 60 mg prefilled syringe <input type="checkbox"/> 90 mg prefilled syringe <input type="checkbox"/> 120 mg prefilled syringe	<input type="checkbox"/> Inject 90 mg (1 syringe) SC every 4 weeks <input type="checkbox"/> Other: Inject _____ mg (1 syringe) SC every 4 weeks	<input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Somavert	<input type="checkbox"/> 10 mg vial <input type="checkbox"/> 15 mg vial <input type="checkbox"/> 20 mg vial <input type="checkbox"/> 25 mg vial <input type="checkbox"/> 30 mg vial	<input type="checkbox"/> Inject ____ mg SC once daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> ____ 10 mg vial kits <input type="checkbox"/> ____ 15 mg vial kits <input type="checkbox"/> ____ 20 mg vial kits 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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<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	

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.

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