Retinal Disorders/Ocular Specialty 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 Sub				
		te or include demographic shee				
Patient Name:Address:			DOB: Geno	der: 🗌 Male 🔲 Female		
Address:		City, State, 2	ZIP Code:			
Preferred Conta below)	act Methods 🗌 Phone (t	o primary # provided below) [Text (to cell # provided below)	Email (to email provided		
Note: Carrier ch	harges may apply. By pro	viding the phone number(s) and	d email address above, you are conse	enting to receive		
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			email, Specialty Pharmacy will attemp			
Primary Phone:	:		Alternate Phone:			
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Parent/Caregiv	er/Guardian Name (Last	Relationship to pati	ent:			
	R INFORMATION					
			State License #:			
NPI#:	DEA #:	Group or Hospital:				
Phone:	 Fax	Contact Person:	State, ZIP Code: Contact's Pl	hone:		
INSURANCI	E INFORMATION Please	a fav conv of prescription and insurance	e cards with this form, if available (front and bac	k)		
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	AND CLINICAL INFO		Patient Office Other:			
Needs by Date. Diagnosis (ICD		Ship to: [
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Patient Clinica			Allected eye(s). 🔃 Right Eye 📋 Leit	Eye I Bour Eyes		
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Allergies:	nly be used once per life	time per eve	in/cm Weight:	_tb./ kg		
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	received a prior Durysta	implant in the treatment eye?	☐ res ☐ No			
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		per the FDA labeled indication				
Medication pres Susvimo :	scribea	·	Date prescribed			
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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.

Retinal Disorders/Ocular Specialty Enrollment Form

Please Complete Patient and Prescriber Information								
Patient Name:Patient Phone:Patient Phone:Prescriber Phone:Prescriber Phone:								
5 PRESCRIPTION INFORMATION								
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS				
☐ Cimerli	0.3 mg/0.05 mL single-dose vial 0.5 mg/0.05 mL single-dose vial	affected eye(s) once	ninister 0.3 mg by intravitreal injection into e a month (approximately 28 days) ninister 0.5 mg by intravitreal injection into e a month (approximately 28 days)	Quantity: Refills:				
☐ Durysta	1 applicator	To be injected by physician as directed Other:		Quantity:				
☐ Eylea	☐ Vial	☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks. ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment. ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks. ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) ☐ Pediatric - Inject 0.4mg (0.01mL) ☐ Other:		Quantity: Refills:				
☐ Eylea HD	☐ 8mg	☐ Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by 8 mg every 8 to 16 weeks (2 to 4 months) ☐ Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by every 8 to 12 weeks (2 to 3 months) ☐ Other:		Quantity: Refills:				
□ Iluvien	1 applicator	To be injected by physician as directed Other:		Quantity:				
□ Izervay	2 mg single-dose vial (0.1 mL of 20 mg/mL solution)	Prepare and administer 2 mg by intravitreal injection into each affected eye once monthly (approximately 28 days) Other:		Quantity: Refills:				
Lucentis	0.3 mg/0.05 mL single-dose PFS 0.3 mg/0.05 mL single-dose vial 0.5 mg/0.05 mL single-dose PFS 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other:		Quantity: Refills:				
Ozurdex	1 applicator	To be injected by physician as directed Other:		Quantity: Refills:				
Retisert	1 implant	☐ To be implanted by physician as directed ☐ Other:		Quantity:				
Susvimo Refill Kit	1 Refill Kit		physician as directed	Quantity: Refills:				
☐ Vabysmo	☐ 6 mg	☐ To be injected by physician as directed ☐ Other:		Quantity: Refills:				
Visudyne	☐ Vial	☐ To be infused by physician as directed ☐ Other:		Quantity: Refills:				
☐ Xdemvy	☐ 0.25%	☐ Instill one drop ir apart) for 6 weeks ☐ Other:	Quantity: Refills:					
☐ Yutiq	0.18 mg (single dose implant)	☐ To be injected by physician as directed ☐ Other:		Quantity: Refills:				
Other:	Strength:	Dose:		Quantity: Refills:				
Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)								
DAW / May Not Su Prescriber's S	ren" / Brand Medically Necessary / Do Not Substitute ignature:	tute / No Substitution /	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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