

# Specialty Pharmacy Fertility Care Program Enrollment Form

**Fax Referral To: 1-866-310-4139    Phone: 1-877-269-4831    Email Referral To: [Customer.ServiceFax@CVSHealth.com](mailto:Customer.ServiceFax@CVSHealth.com)**

## 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 CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg    Height: \_\_\_\_\_ in/cm

### 5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cetrotide 0.25 mg Syringe	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ganirelix 250 mcg/0.5mL	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Leuprolide 2 Week Kit	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Leuprolide Micro Dose _____ mcg / _____ mL	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Follistim AQ 300 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Follistim AQ 600 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Follistim AQ 900 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Follistim Pen	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gonal-F 450 IU MDV	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gonal-F 1050 IU MDV	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gonal-F RFF Rediject 300 IU Pen	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gonal-F RFF Rediject 450 IU Pen	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gonal-F RFF Rediject 900 IU Pen	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Menopur 75 IU Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> HCG Low Dose _____ Units / _____ mL Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> HCG 10,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Novarel 5,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Pregnyl 10,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ovidrel 250 mcg / 0.5 mL	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Crinone 8% Gel	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Endometrin 100 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prometrium _____ mg	<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 <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.

# Specialty Pharmacy Fertility Care Program Enrollment Form

## 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"/> Progesterone Compounded Capsules ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Progesterone Suppositories ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Progesterone / Sesame Oil 50 mg / mL Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Progesterone( ____ ) 50 mg / mL Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Delestrogen ____ mg / mL	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Syringe 1 mL only	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Syringe 3 mL only	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Syringe 3 mL 18 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Syringe 3 mL 22 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 18 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 22 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 25 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 25 g 5/8"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 27 g 0.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Needle 30 g 0.5"	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Insulin Syringe ____ mL	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Aspirin 81 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Azithromycin ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Cabergoline 0.5 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Citranatal _____	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Clomiphene 50 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Dexamethasone ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Doxycycline 100 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Estradiol ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Folic Acid 1 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Letrozole 2.5 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Methylprednisolone ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Prednisone ____ mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Prenatal Plus	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Z-Pak 250 mg #6 Tablets	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Climara 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Minivelle 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Vivelle DOT 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Heparin ____ units / mL Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Lovenox ____ mg Syringes	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

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**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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