

# Sickle Cell Disease 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):

D57.1 Sickle-cell Disease  Other Code: \_\_\_\_\_ Description \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

#### Nursing: (for Adakveo)

Specialty pharmacy to coordinate home health nursing?  Yes  No Port?  Yes  No  
Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Infusion  Other \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Adakveo	100 mg/10 ml single dose vial	Infuse _____ mg (5mg/kg) intravenously in normal saline (for total volume 100ml) over 30 minutes on week 0, week 2 and every 4 weeks thereafter.  Patient weight: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply Refills: _____
<input type="checkbox"/> Endari	5-gram packet	Take _____ grams orally twice per day. Mix Endari powder immediately before ingestion with 8 ounces of cold or room temperature beverage or 4-6 ounces of food.	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply 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.