



# Nuzyra Enrollment Form

Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

## 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. 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 #: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_

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):

J18.9 Pneumonia  L08.9 Local infection of the skin and subcutaneous tissue

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

#### Patient Clinical Information:

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

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

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

### 5 PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Nuzyra	150 mg	Other: _____ _____	Quantity: <input type="checkbox"/> 6-count pack <input type="checkbox"/> Other: _____  Refills: N/A

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.

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