Retinal Disorders/Ocular Specialty Enrollment Form



Fax Referral To: 1-800-323-2445 Phone: 1-800-237-2767 Email Referral To: Customer.ServiceFax@CVSHealth.com



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PATIENT INFORMATION			et)				
Patient Name:			DOB:	Gend	ler: 🗌 Male 🔲 Female		
Address:							
Preferred Contact Methods					Email (to email provided		
below)	_ ` ' '	. , -	_ ` '	, <u> </u>			
Note: Carrier charges may app	oly. By providing the ph	none number(s) an	nd email address ab	ove, vou are conse	nting to receive		
automated calls, emails and/o							
rates apply. Message frequence							
	-						
	Alternate Phone: Last Four of SSN: Primary Language:						
arent/Caregiver/Guardian Name (Last, First):							
PRESCRIBER INFORMAT							
Prescriber's Name:			State License #				
NPI #: DEA #: _	Group or	- Hospital	0tate Electioe #.				
Address: Phone:		Contact Person:	Otato, 211 Oodo	Contact's Ph	none:		
INSURANCE INFORMAT							
			e cards with this form, if a	ivaliable (front and back	()		
4 DIAGNOSIS AND CLINIC		_	¬ъ □ o				
Needs by Date:		Ship to: L	Patient 🗌 Office	Other:			
Diagnosis (ICD-10):							
ICD-10 Code: D	·		Affected eye(s): 🗌	Right Eye Left I	Eye 🔲 Both Eyes		
Patient Clinical Information:							
Allergies:			in/cm	Weight:	lb./kg		
Durysta: Can only be used on							
Has the patient received a price	or Durysta implant in t	he treatment eye?	P ∐ Yes ∐ No				
Iluvien:							
Medication prescribed							
			Date prescribed				
Medication prescribed Susvimo : Previous response to at least 2	2 intravitreal injections		Date prescribed				
Medication prescribed Susvimo : Previous response to at least 2 per the FDA labeled indication	2 intravitreal injections n for Susvimo :	of a vascular endo	Date prescribed othelial growth fact	or (VEGF) inhibitor	medication are required		
Medication prescribed Susvimo : Previous response to at least 2 per the FDA labeled indication Medication prescribed	2 intravitreal injections n for Susvimo :	of a vascular endo	Date prescribed othelial growth fact _ Date prescribed	or (VEGF) inhibitor	medication are required		
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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:Patient Phone:Patient 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	☐ 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:				
☐ 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 followed by 8 mg every Inject 8 mg ever followed by every 8	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 adm affected eye once m ☐ 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 adm affected eye(s) once Prepare and adm affected eye(s) once	Quantity: Refills:					
Ozurdex	1 applicator	☐ To be injected by ☐ Other:	Quantity: Refills:					
Retisert	1 implant	☐ To be implanted by physician as directed ☐ Other:		Quantity:				
Susvimo Refill Kit	1 Refill Kit	To be injected by physician as directed Other:		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 in each eye twice daily (approximately 12 hours 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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