



Transplant 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)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

- | | | |
|---|--|---|
| <input type="checkbox"/> Z94.0 Kidney Transplant Status | <input type="checkbox"/> Z94.1 Heart Transplant Status | <input type="checkbox"/> Z94.2 Lung Transplant Status |
| <input type="checkbox"/> Z94.3 Heart and Lung Transplant Status | <input type="checkbox"/> Z94.4 Liver Transplant Status | <input type="checkbox"/> Z94.5 Skin Transplant Status |
| <input type="checkbox"/> Z94.6 Bone Transplant Status | <input type="checkbox"/> Z94.7 Corneal Transplant Status | <input type="checkbox"/> Z94.81 Bone Marrow Transplant Status |
| <input type="checkbox"/> Z94.82 Intestine Transplant Status | <input type="checkbox"/> Z94.83 Pancreas Transplant Status | <input type="checkbox"/> Z94.84 Stem Cells Transplant Status |
| <input type="checkbox"/> Other Code: _____ Description: _____ | | |

Required Information for Organ Transplant Patients:

Patient Medicare status (check all that apply):
 Had Medicare at time of transplant Currently has Medicare Does not have Medicare

If patient has Medicare, please provide Medicare ID: _____

Date of Transplant: _____ Discharge Date: _____

Hospital Name, City and State: _____

For Kidney Transplant: Initial Dialysis Date _____ Type of Dialysis Hemo Peritoneal

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

5 PRESCRIPTION INFORMATION (DIABETIC SUPPLIES)

Not a Diabetic
 Insulin Non-Insulin Diagnosis Code: _____

Glucometer: _____

Test Strips: _____

Lancets: _____

0.5 cc Insulin Syringes: _____

Short Acting Insulin: _____

Long-Acting Insulin: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

Transplant Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION (IMMUNOSUPPRESSANTS)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Astagraf XL	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Azasan	<input type="checkbox"/> 75 mg <input type="checkbox"/> 100 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cellcept	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 200 mg/mL	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Envarsus XR	<input type="checkbox"/> 0.75 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 4 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gengraf	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 100 mg/mL	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Imuran	50 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Myfortic	<input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neoral	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 100 mg/mL	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Nulojix	250 mg vial	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prograf	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rapamune	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 1 mg/mL	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Sandimmune	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 100 mg/mL	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zortress	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 0.50 mg <input type="checkbox"/> 0.75 mg	Other: _____	Quantity: _____ Refills: _____

5 PRESCRIPTION INFORMATION (OTHER)

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> PCP Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> PCP Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> CMV Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> CMV Prophylaxis: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Thrush (Candida): _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Hematopoietics: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Hematopoietics: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gastrointestinal: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	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 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.

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