

Retinal Disorders/Ocular Specialty Enrollment Form



Fax Referral To: 1-855-297-1270

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190

NCPDP: 4026325

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/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):

ICD-10 Code: _____ Diagnosis: _____ Affected eye(s): Right Eye Left Eye Both Eyes

Patient Clinical Information:

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

Durysta: Can only be used once per lifetime per eye.

Has the patient received a prior **Durysta** implant in the treatment eye? Yes No

Iluvien:

Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:

Medication prescribed _____ Date prescribed _____

Susvimo:

Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo**:

Medication prescribed _____ Date prescribed _____

Medication prescribed _____ Date prescribed _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Beovu	<input type="checkbox"/> Vial <input type="checkbox"/> PFS	Induction dose: <input type="checkbox"/> Inject 6 mg monthly for the first three doses <input type="checkbox"/> Inject 6 mg every 6 weeks for the first five doses <input type="checkbox"/> Other: _____ Maintenance dose: <input type="checkbox"/> Inject 6 mg every 8 to 12 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Byooviz	<input type="checkbox"/> 0.5 mg single-dose vial	<input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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.

Retinal Disorders/Ocular Specialty Enrollment Form

Please Complete Patient and Prescriber Information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cimerli	<input type="checkbox"/> 0.3 mg/0.05 mL single-dose vial <input type="checkbox"/> 0.5 mg/0.05 mL single-dose vial	<input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Durysta	<input type="checkbox"/> 1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Eylea	<input type="checkbox"/> Vial <input type="checkbox"/> PFS	<input type="checkbox"/> 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 <input type="checkbox"/> Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment <input type="checkbox"/> 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 <input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) <input type="checkbox"/> Pediatric - Inject 0.4mg (0.01mL) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Eylea HD	<input type="checkbox"/> 8mg	<input type="checkbox"/> Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by 8 mg every 8 to 16 weeks (2 to 4 months) <input type="checkbox"/> Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by every 8 to 12 weeks (2 to 3 months) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Iluvien	<input type="checkbox"/> 1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Izervay	<input type="checkbox"/> 2 mg single-dose vial (0.1 mL of 20 mg/mL solution)	<input type="checkbox"/> Prepare and administer 2 mg by intravitreal injection into each affected eye once monthly (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lucentis	<input type="checkbox"/> 0.3 mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.3 mg/0.05 mL single-dose vial <input type="checkbox"/> 0.5 mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.5 mg/0.05 mL single-dose vial	<input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ozurdex	<input type="checkbox"/> 1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Retisert	<input type="checkbox"/> 1 implant	<input type="checkbox"/> To be implanted by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Susvimo Refill Kit	<input type="checkbox"/> 1 Refill Kit	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Vabysmo	<input type="checkbox"/> 6 mg	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Visudyne	<input type="checkbox"/> Vial	<input type="checkbox"/> To be infused by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xdemvy	<input type="checkbox"/> 0.25%	<input type="checkbox"/> Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yutiq	<input type="checkbox"/> 0.18 mg (single dose implant)	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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

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