

Wilson's Disease 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. 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

Diagnosis (ICD-10):

E83.0 Disorders of Copper Metabolism H18.0 Corneal Pigmentation and Deposits E72.01 Cystinuria

Other Code: _____ Description: _____

Patient Clinical Information:

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

First time receiving Wilson's Disease therapy? Yes No

If No, previous product used: _____

Documented reactions to Wilson's Disease therapy: _____

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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"/> Cuprimine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Depen (Titratable Tablets)	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Penicillamine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Penicillamine (Titratable Tablets)	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Syprine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Trientine	250 mg	<input type="checkbox"/> 250 mg by mouth <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID <input type="checkbox"/> Other _____	Quantity: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

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 tele phone and destroy all copies of this communication and any attachments.

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