Sickle Cell Disease Enrollment Form

CVS specialty®

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):

☐ D57.1 Sickle-cell Disease ☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

Nursing: (for Adakveo)

Specialty pharmacy to coordinate home health nursing? ☐ Yes ☐ No Port? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Infusion ☐ Other _____

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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
☐ Adakveo	100 mg/10 ml single dose vial	Infuse _____ mg (5mg/kg) intravenously in normal saline (for total volume 100ml) over 30 minutes on week 0, week 2 and every 4 weeks thereafter. Patient weight: _____	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply Refills: _____
☐ Endari	5-gram packet	Take _____ grams orally twice per day. Mix Endari powder immediately before ingestion with 8 ounces of cold or room temperature beverage or 4-6 ounces of food.	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply Refills: _____
☐ Oxbryta	500 mg tablets	☐ Take 1500 mg orally once daily ☐ Other: _____	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply Refills: _____
☐ Oxbryta	300 mg tablets for oral suspension	Take _____ mg orally once daily. Patient weight: _____ Disperse tablets in room temperature, clear liquid before swallowing. Follow additional information provided for oral suspension. Do not swallow whole, cut, crush or chew tablets for oral suspension.	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply 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.