Hematopoietic: Hepatitis C Enrollment Form

Medications A-P

(Epogen, Procrit)

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):

☐ D63.8 Anemia in other chronic diseases classified elsewhere ☐ 285.29 Anemia of other chronic disease
☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epogen	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: _____ ☐ Multi-dose Vial (MDV): Inject _____ mL (_____units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: _____	Quantity: _____ Refills: _____
☐ Procrit	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: _____ ☐ Multi-dose Vial (MDV): Inject _____ mL (_____units) SC ☐ Once a Week ☐ 3 Times a Week ☐ 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.

Hematopoietic: Hepatitis C Enrollment Form
Medications P-Z
(Promacta, Retacrit)

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
☐ Promacta	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg	☐ _____ mg PO _____ times per day	Quantity: _____ Refills: _____
☐ Retacrit	☐ 2000 u/mL ☐ 3000 u/mL ☐ 4000 u/mL ☐ 10,000 u/mL ☐ 40,000 u/mL	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: _____ ☐ Multi-dose Vial (MDV): Inject _____ mL (_____units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: _____	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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