

# Sunlenca Enrollment Form



Fax Referral To: 1-877-733-3199

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-877-602-5889

## 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):**

B20 Human Immunodeficiency Virus (HIV) Disease

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### **Patient Clinical Information:**

Allergies: \_\_\_\_\_

NKDA

Treatment status:

New to therapy  Continuation of therapy: Date of last treatment \_\_\_\_/\_\_\_\_/\_\_\_\_

CD4 Count \_\_\_\_\_ Viral load \_\_\_\_\_

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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"/> Sunlenca	<input type="checkbox"/> 300 mg tablets <input type="checkbox"/> 463.5 mg/1.5 mL vials	<input type="checkbox"/> <b>Loading dose Option 1</b> 927 mg by subcutaneous injection (2 x 1.5 mL injections) and 600 mg orally (2 x 300 mg tablets) on Day 1 Then 600 mg orally (2 x 300 mg tablets) on Day 2	<input type="checkbox"/> <b>Loading dose 1</b> Quantity: (1) 300 mg-4 tablet blister pack (1) Injection dosing kit (contains 2 vials)  Refills: <u>0</u>
		<input type="checkbox"/> <b>Loading dose Option 2</b> 600 mg orally (2 x 300 mg tablets) on Day 1 600 mg orally (2 x 300 mg tablets) on Day 2 300 mg orally (1 x 300 mg tablet) on Day 8 Then 927 mg by subcutaneous injection (2 x 1.5 mL injections) on Day 15	<input type="checkbox"/> <b>Loading dose 2</b> Quantity: (1) 300 mg-5 tablet blister pack (1) Injection dosing kit (contains 2 vials)  Refills: <u>0</u>
		<input type="checkbox"/> <b>Maintenance Dose</b> 927 mg by subcutaneous injection (2 x 1.5 mL injections) every 6 months (26 weeks) from the date of the last injection (+/- 2 weeks).	<input type="checkbox"/> <b>Maintenance</b> Quantity: (1) Injection dosing kit (contains 2 vials)  Refills: <u>1</u>

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	May Substitute / Product Selection Permitted / Substitution Permissible
<b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	<b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " _____ <b>ATTN: New York and Iowa providers,</b> 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 telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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