

Lupron Depot/Eligard/Zoladex/Firmagon Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com

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

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ _____ _____ _____

State License #: _____ NPI #: _____ DEA #: _____ Address: _____

City, State, ZIP Code: _____ Group or Hospital: _____

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):

C61 Malignant neoplasm of prostate Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

Height: _____ in/cm

Weight: _____ lb/kg

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Please Complete Patient and Prescriber Information

Patient Name: _____
 Prescriber Name: _____

Patient DOB: _____
 Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Lupron Depot:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Lupron Depot 7.5 mg (1-month supply)	Administer IM once a month	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot 22.5 mg (3-month supply)	Administer IM once every 3 months	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot 30 mg (4-month supply)	Administer IM once every 4 months	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot 4 5 mg (6-month supply)	Administer IM once every 6 months	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____

Eligard:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Eligard 7.5 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Eligard Depot 22.5 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Eligard Depot 30 mg (4-month supply)	Administer SC once every 4 months	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Eligard 45 mg (6-month supply)	Administer SC once every 6 months	Quantity: 1 kit Refills: _____

Zoladex:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Zoladex 3.6 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Zoladex 10.8 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: _____

Firmagon:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Firmagon 120 mg/vial treatment pack (2 vials)	As an initial dose, administer 240 mg SC as two injections of 120mg each	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Firmagon 80 mg/vial	Administer 80 mg SC every 28 days	Quantity: 1 kit 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.

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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