

Renal Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

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

NCPDP: 4026325

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

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____ 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):

Code: _____ Description: _____ Code: _____ Description: _____

Allergies: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Filspari	NA	Please complete Filspari Patient Enrollment and Consent form; and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.traveretotalcare.com or by calling 1-833-345-7727. Fax enrollment form to 888-381-0625. Note: Filspari is only available through a restricted program called the Filspari Risk Evaluation and Mitigation Strategy (REMS) Program because of the risk of liver problems and serious birth defects. Patient and prescriber forms can be accessed at Filsparirems.com .	Quantity: 0 Refills: 0
<input type="checkbox"/> Parsabiv	<input type="checkbox"/> 2.5 mg/0.5mL <input type="checkbox"/> 5 mg/mL <input type="checkbox"/> 10 mg/2mL	<input type="checkbox"/> Initiation: 5mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment <input type="checkbox"/> Maintenance: _____ mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rivfloza	NA	All referrals must be sent through the manufacturer's HUB, NovoCare. Please visit www.novocare.com for more information.	Quantity: 0 Refills: 0
<input type="checkbox"/> Other:	<input type="checkbox"/> _____	<input type="checkbox"/> 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: _____
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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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