

Sickle Cell Disease 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: _____

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 #: _____

Group or Hospital: _____

Address: _____ City, State, ZIP: _____

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: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> 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: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply Refills: _____
<input type="checkbox"/> Oxbrtya	500 mg tablets	<input type="checkbox"/> Take 1500 mg orally once daily <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply Refills: _____
<input type="checkbox"/> Oxbrtya	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: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 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.

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