

Hematopoietic: Hepatitis C Enrollment Form

Medications A-P

(Epoen, Procrit)



Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

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 #: _____ 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
<input type="checkbox"/> Epoen	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Procrit	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <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: _____
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: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Promacta	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/> _____ mg PO _____ times per day	Quantity: _____ Refills: _____
<input type="checkbox"/> Retacrit	<input type="checkbox"/> 2000 u/mL <input type="checkbox"/> 3000 u/mL <input type="checkbox"/> 4000 u/mL <input type="checkbox"/> 10,000 u/mL <input type="checkbox"/> 40,000 u/mL	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) SC <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <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

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