

Hematopoietic Enrollment Form

Medications A-D



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):

Code: _____ Description: _____

Code: _____ Description: _____

Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

Height: _____ in/cm

Weight: _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Aranesp	Single-dose Vials: <input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 150 mcg/.75 mL <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 500 mcg/1 mL Single-dose Prefilled Syringes: <input type="checkbox"/> 10 mcg/0.4 mL <input type="checkbox"/> 25 mcg/0.42 mL <input type="checkbox"/> 40 mcg/0.4 mL <input type="checkbox"/> 60 mcg/0.3 mL <input type="checkbox"/> 100 mcg/0.5 mL <input type="checkbox"/> 150 mcg/0.3 mL <input type="checkbox"/> 200 mcg/0.4 mL <input type="checkbox"/> 300 mcg/0.6 mL <input type="checkbox"/> 500 mcg/1 mL	<input type="checkbox"/> Inject the entire contents of vial/syringe SC once every other week <input type="checkbox"/> Inject the entire contents of vial/syringe SC once a week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Doptelet	20 mg tablet	<input type="checkbox"/> Take __ tablet(s) by mouth once daily <input type="checkbox"/> Take __ tablets by mouth once daily for 5 days beginning 10-13 days before procedure <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. ©2022 CVS Specialty and/or one of its affiliates. 75-46757A 03/28/22 Page 1 of 2

Hematopoietic Enrollment Form

Medications E-Z

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"/> Epogen	<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"/> Fulphila	6 mg Prefilled Syringe	<input type="checkbox"/> Inject 6 mg SC day after chemotherapy, every _____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Leukine	<input type="checkbox"/> 250 mcg vial (lyophilized) <input type="checkbox"/> 500 mcg/mL vial (liquid)	<input type="checkbox"/> Administer _____ mcg once a day for _____ days (Circle: IV or SC)	Quantity: _____ Refills: _____
<input type="checkbox"/> Neulasta	6 mg Prefilled Syringe	<input type="checkbox"/> Inject 6 mg SC day after chemotherapy, every _____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neumega	5 mg vial kit	<input type="checkbox"/> Mix and administer 50 ug/kg once a day for _____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neupogen	<input type="checkbox"/> 300 mcg <input type="checkbox"/> 480 mcg <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> Vial	<input type="checkbox"/> Administer _____ mcg once a day for _____ days (Circle: IV or SC) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Nplate	<input type="checkbox"/> 125 mcg (SDV) <input type="checkbox"/> 250 mcg (SDV) <input type="checkbox"/> 500 mcg (SDV)	<input type="checkbox"/> Inject _____ mcg subcutaneously as one-time dose <input type="checkbox"/> Inject _____ mcg subcutaneously once weekly <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: _____
<input type="checkbox"/> Promacta	<input type="checkbox"/> 12.5 mg tablet <input type="checkbox"/> 25 mg tablet <input type="checkbox"/> 50 mg tablet <input type="checkbox"/> 75 mg tablet <input type="checkbox"/> 12.5 mg Powder for Oral Suspension <input type="checkbox"/> 25 mg Powder for Oral Suspension	<input type="checkbox"/> Take _____ tablet(s) by mouth once daily <input type="checkbox"/> Prepare suspension as directed and take _____ packet(s) by mouth once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Udenyca	6 mg Prefilled Syringe	<input type="checkbox"/> Inject 6 mg SC day after chemotherapy, every _____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zarxio	<input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer _____ mcg once a day for _____ days (Circle: IV or SC) <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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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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