

# Procrit Enrollment Form



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):

D63.0 Anemia in neoplastic disease

D63.1 Anemia in chronic kidney disease

D63.8 Anemia in other chronic diseases classified elsewhere

D64.81 Anemia due to antineoplastic chemotherapy

D64.9 Anemia unspecified

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Height: \_\_\_\_\_ in/cm

Weight: \_\_\_\_\_ lb/kg

### 5 PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Procrit epoetin alfa	<input type="checkbox"/> 2,000 units/mL (single-dose vial)	<input type="checkbox"/> Single-dose Vial: 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: _____	Quantity: _____ Refills: _____
	<input type="checkbox"/> 3,000 units/mL (single-dose vial)		
	<input type="checkbox"/> 4,000 units/mL (single-dose vial)		
	<input type="checkbox"/> 10,000 units/mL (single-dose vial)		
	<input type="checkbox"/> 10,000 units/mL – 2 mL vial (multi-dose vial)	<input type="checkbox"/> Multi-dose Vial: Inject _____ mL (_____ units) SC. <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> 20,000 units/mL – 1 mL vial (multi-dose vial)		
	<input type="checkbox"/> 40,000 units/mL (single-dose vial)		
		<input type="checkbox"/> Include 25G 5/8" syringes, alcohol pads, and sharps container – free of charge	

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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