Renal Enrollment Form

CVS specialty®

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: _____ 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
☐ 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
☐ Parsabiv	☐ 2.5 mg/0.5mL ☐ 5 mg/mL ☐ 10 mg/2mL	☐ Initiation: 5mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment ☐ Maintenance: _____ mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment ☐ Other: _____	Quantity: _____ Refills: _____
☐ 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
☐ Other: _____	☐ _____	☐ 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____	**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.