CVS CAREMARK

Specialty Pharmacy Services
Enrollment Form

Fax Referral To: 800-323-2445
Phone: 800-237-2767

Date: _____ **Needs by Date:** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-9:

_____
_____
_____
_____

• Date of Diagnosis: _____

Additional Clinical Information:

• Weight: _____ kg/lbs • Height: _____ in/cm
• Allergies: _____
• Lab Data: _____
• Concomitant Medications: _____
• Additional Comments: _____
_____

Injection Training/Home Health Coordination:

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

_____ (Date) _____ (Date)
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN