# Specialty Pharmacy Services Enrollment Form

**Fax Referral To: 1-800-323-2445** **Phone: 1-866-638-8311**
**Email Referral To: customerservicefax@caremark.com**

## Six Simple Steps to Submitting a Referral

### ❶PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____
Address: _____
City, State, ZIP: _____
Preferred Contact Method: ☐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: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
Email: _____
Last Four of SSN: _____ Primary Language: _____

### ❷ PRESCRIBER INFORMATION

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

### ❸INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

### ❹DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____
Ship to: ☐Patient ☐ Office ☐ Other: _____

**Diagnosis (ICD-10):**
Code: _____ Description: _____ Code: _____ Description: _____
Code: _____ Description: _____ Code: _____ Description: _____
For additional ICD-10 information, please visit www.CVSspecialty.com/ICD10

**Patient Clinical Information:**
Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm
Concomitant Medications: _____
Additional Comments: _____

**Nursing:** Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Injection training is not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD office to alternate trainer

### ❺PRESCRIPTION INFORMATION

| MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ | | | | |
| ☐ | | | | |
| ☐ | | | | |
| ☐ | | | | |
| ☐ | | | | |
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| ☐ | | | | |
| ☐ | | | | |

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration



❻X_____ X_____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)


75-36813A 122215