

# Sickle Cell Disease Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

## Six Simple Steps to Submitting a Referral

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_

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/Caregier/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: \_\_\_\_\_

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):**

D57.1 Sickle-cell Disease  Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### **Patient Clinical Information:**

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

#### **Nursing:** (for Adakveo)

Specialty pharmacy to coordinate home health nursing?  Yes  No Port?  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Infusion  Other \_\_\_\_\_

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## 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"/> Adakveo	100 mg/10 ml single dose vial	Infuse _____ mg (5mg/kg) intravenously in normal saline (for total volume 100ml) over 30 minutes on week 0, week 2 and every 4 weeks thereafter.  Patient weight: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply Refills: _____
<input type="checkbox"/> Oxbritya	500 mg tablets	<input type="checkbox"/> Take 1500 mg orally once daily <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply Refills: _____
<input type="checkbox"/> Oxbritya	300 mg tablets for oral suspension	Take _____ mg orally once daily.  Patient weight: _____  Disperse tablets in room temperature, clear liquid before swallowing. Follow additional information provided for oral suspension. Do not swallow whole, cut, crush or chew tablets for oral suspension.	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> 12-month supply 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 <b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words “ <b>No Substitution</b> ” _____	
<b>ATTN: New York and Iowa providers,</b> 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.

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