

Allergies: _

3 ⊿

Hematopoietic Enrollment Form

Medications A-D

Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com

		Address: 280 Avenida	a Jesus T. Pinero S	te B Rio Piedras, PR 00927
		Six Simple Steps to	Submitting a R	eferral
PATIENT IN	NFORMATION	(Complete or include demogr	raphic sheet)	
Patient Name:				DOB:
Address:			City, State, ZIF	P Code:
Gender: 🗌 Male	🗌 Female			
Preferred Contac	t Methods: 🗌 Phone	e (to primary # provided below) [Text (to cell # prov	ided below) 🗌 Email (to email provided below)
Note: Carrier charge	es may apply. If unable	e to contact via text or email, Spec	cialty Pharmacy will a	ttempt to contact by phone.
Primary Phone: _			Alternate Ph	one:
If Minor, Parent/0	Caregiver/Guardiar	n Name (Last, First):		
Relationship to n	ninor:			
Email:		Last	Four of SSN:	Primary Language:
2 PRESCRIB	ER INFORMAT	ION		
			State Lice	nse #:
Address:			City, State, ZIP Co	de:
				Contact's Phone:

INS	URANCE INFOR	RMATION Please fax	copy of prescription a	and insurance card	ls with this form, i	f available (fro	ont and back)
DIA	GNOSIS AND C	LINICAL INFORM	IATION				

Needs by Date:	Ship to: Patient Office Other:
Diagnosis (ICD-10):	
Code:	Description:
Code:	Description:

Code:	Description:
Datient Clinical Ir	formation

5 PRESCRIPTION INFORMATION

	Height:	in/cm
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Weight: ____lb/kg

MEDICATION	STRENGTH	DO	SE & DIRECTIONS	QUANTITY/REFILLS
Aranesp	Single-dose Vials: 25 mcg 40 mcg 60 mcg 100 mcg 150 mcg/.75 mL 200 mcg 300 mcg 500 mcg/1 mL Single-dose Prefilled Syringes: 10 mcg/0.4 mL 25 mcg/0.42 mL 40 mcg/0.4 mL 60 mcg/0.3 mL 100 mcg/0.5 mL 300 mcg/0.6 mL 500 mcg/1 mL	 Inject the entire contents of vial/syringe SC once every other week Inject the entire contents of vial/syringe SC once a week Other:		eek Quantity: Refills:
Doptelet	20 mg tablet	Take _ tablet(s) by m Take _ tablets by mo 10-13 days before proced Other:	uth once daily for 5 days beginning lure	Quantity: Refills:
Patient is interested	d in patient support programs	STAMP SIGNATURE NOT A		provided as needed for administratic
	OPRESCRIBER SIGNAT	URE REQUIRED (S	TAMP SIGNATURE NOT ALLO	WED)
"Dispense As Writ DAW / May Not Su	ten" / Brand Medically Necessary / Do Not Substitute	ubstitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	

Prescriber's Signature:

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. ©2022 CVS Specialty and/or one of its affiliates. 75-46757A 03/28/22 Page 1 of 2

Date:

Hematopoietic Enrollment Form Medications E-Z

	Please Co	omplete Patient and Prescriber Information				
-		Patient DOB:				
Prescriber Name: Prescriber Phone:						
5 PRESCRI	PTION INFORMATION					
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS			
Epogen	 2,000 u/mL (SDV) 3,000 u/mL (SDV) 4,000 u/mL (SDV) 10,000 u/mL (SDV) 10,000 u/mL-2 mL vial (MDV) 20,000 u/mL-1 mL vial (MDV) 	Single-dose Vial (SDV): Inject the entire contents of 1 vial SC Once a Week 3 Times a Week Other: Multi-dose Vial (MDV): Inject mL (units) SC Once a Week 3 Times a Week Other:	Quantity: Refills:			
🗌 Fulphila	6 mg Prefilled Syringe	Inject 6 mg SC day after chemotherapy, every days Other:	Quantity: Refills:			
Leukine	250 mcg vial (lyophilized) 500 mcg/mL vial (liquid)	Administermcg once a day fordays (Circle: IV or SC)	Quantity: Refills:			
🗌 Neulasta	6 mg Prefilled Syringe	Inject 6 mg SC day after chemotherapy, every days Other:	Quantity: Refills:			
🗌 Neumega	5 mg vial kit	Mix and administer 50 ug/kg once a day for days Other:	Quantity: Refills:			
🗌 Neupogen	300 mcg 480 mcg Prefilled Syringe Vial	Administer mcg once a day fordays (Circle: IV or SC) Other:	Quantity: Refills:			
☐ Nplate	☐ 125 mcg (SDV) ☐ 250 mcg (SDV) ☐ 500 mcg (SDV)	Inject _ mcg subcutaneously as one-time dose Inject _mcg subcutaneously once weekly Other:	Quantity: Refills:			
Procrit	2,000 u/mL (SDV) 3,000 u/mL (SDV) 4,000 u/mL (SDV) 10,000 u/mL (SDV) 10,000 u/mL-2 mL vial (MDV) 20,000 u/mL-1 mL vial (MDV)	Single-dose Vial (SDV): Inject the entire contents of 1 vial SC Once a Week 3 Times a Week Other: Multi-dose Vial (MDV): Inject mL (units) SC Once a Week 3 Times a Week Other:	Quantity: Refills:			
Promacta	12.5 mg tablet 25 mg tablet 50 mg tablet 75 mg tablet 12.5 mg Powder for Oral Suspension 25 mg Powder for Oral Suspension 25 mg Powder for Oral Suspension Suspension	Take tablet(s) by mouth once daily Prepare suspension as directed and take packet(s) by mouth once daily Other:	Quantity: Refills:			
Udenyca	6 mg Prefilled Syringe	Inject 6 mg SC day after chemotherapy, every days Other:	Quantity: Refills:			
Zarxio	300 mcg Prefilled Syringe 480 mcg Prefilled Syringe	Administer mcg once a day fordays (Circle: IV or SC) Other: STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits prov	Quantity: Refills: ided as needed for administratic			

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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 subm			lers, please submit electronic prescription

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