Forteo 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: ______________________________ 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. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: ____________________ Alternate Phone: _________________ DOB: _______________ Gender: ☐ Male ☐ Female

Email: ____ Last Four of SSN: ____________ Primary Language: ________________

2 PRESCRIBER INFORMATION

Prescriber's Name: ____ 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

Diagnosis (ICD-10):

☐ M81.00 age-related osteoporosis without current pathological fracture
☐ M81.6 localized osteoporosis
☐ M81.8 other osteoporosis without current pathological fracture
☐ Other Code: ______ Description: _______________

Patient Clinical Information:

Allergies: _________________________________ Height: _____in/cm Weight: _____lb/kg

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Forteo	600 mcg/2.4 ml Delivery Device	Inject 20 ug (0.08 ml) subcutaneous once daily.	Quantity: ☐ 1 device (28-day supply) ☐ 3 devices (84-day supply) Refills: __________
☐ Forteo	NEEDLES 31 gauge: ☐ 5 mm ☐ 6 mm ☐ 8 mm	Use with Forteo Delivery Device as directed.	Quantity: ☐ 4-week supply ☐ 12-week supply Refills: __________
☐ Other: __________	Other: ______________	Other: ____	Quantity: _________ Refills: __________
☐ Other: __________	Other: ______________	Other: ____	Quantity: _________ Refills: __________
☐ Other: __________	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 PHYSICIAN SIGNATURE REQUIRED

DISPENSE AS WRITTEN (Date)
X____

PRODUCT SUBSTITUTION PERMITTED (Date)
X____

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.