

Forteo Enrollment Form



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
<input type="checkbox"/> Forteo	600 mcg/2.4 ml Delivery Device	Inject 20 ug (0.08 ml) subcutaneous once daily.	Quantity: <input type="checkbox"/> 1 device (28-day supply) <input type="checkbox"/> 3 devices (84-day supply) Refills: _____
<input type="checkbox"/> Forteo	NEEDLES 31 gauge: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Forteo Delivery Device as directed.	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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)

PRODUCT SUBSTITUTION PERMITTED

(Date)

X _____ 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.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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