

# Retinal Disorders/Ocular Specialty 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: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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/Caregiver/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 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

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

#### **Diagnosis (ICD-10):**

ICD-10 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Affected eye(s):  Right Eye  Left Eye  Both Eyes

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

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

**Durysta:** Can only be used once per lifetime per eye.

Has the patient received a prior **Durysta** implant in the treatment eye?  Yes  No

#### **Iluvien:**

Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

#### **Susvimo:**

Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo**:

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

# Retinal Disorders/Ocular Specialty Enrollment Form

## 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"/> Beovu	Vial	<b>Induction dose:</b> <input type="checkbox"/> Inject 6 mg monthly for the first three doses <input type="checkbox"/> Other: _____ <b>Maintenance dose:</b> <input type="checkbox"/> Inject 6 mg every 8 to 12 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Durysta	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Eylea	<input type="checkbox"/> Vial <input type="checkbox"/> PFS	<input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks <input type="checkbox"/> Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment <input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks <input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Iluvien	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Lucentis	<input type="checkbox"/> 0.3 mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.3 mg/0.05 mL single-dose vial <input type="checkbox"/> 0.5 mg/0.05 mL single-dose PFS <input type="checkbox"/> 0.5 mg/0.05 mL single-dose vial	<input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ozurdex	1 applicator	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Retisert	1 implant	<input type="checkbox"/> To be implanted by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____
<input type="checkbox"/> Susvimo	1 implant	<input type="checkbox"/> To be implanted by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Vabysmo	6 mg	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Visudyne	Vial	<input type="checkbox"/> To be infused by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yutiq	0.18 mg (single dose implant)	<input type="checkbox"/> To be injected by physician as directed <input type="checkbox"/> Other: _____	Quantity: _____ 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

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

May Substitute / Product Selection Permitted / Substitution Permissible

**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.

**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.

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

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates. ©2022 CVS Specialty and/or one of its affiliates. 75-46713A