

# Specialty Pharmacy Services Enrollment Form



Fax Referral To: 1-800-567-8000

Phone: 1-800-238-7828

Email Referral To: [customerservicefax@caremark.com](mailto:customerservicefax@caremark.com)

## Six Simple Steps to Submitting a Referral

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

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

Preferred Contact Method:  Phone  Text  Email  
(to primary # provided below) (to cell # provided below) (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: \_\_\_\_\_  Home  Cell  Work  
 Alternate Phone: \_\_\_\_\_  Home  Cell  Work  
 DOB: \_\_\_\_\_ Gender:  Male  Female  
 E-mail: \_\_\_\_\_  
 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: Fidelis** 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):**  
 Code: \_\_\_\_\_ Description: \_\_\_\_\_ Code: \_\_\_\_\_ Description: \_\_\_\_\_  
 Code: \_\_\_\_\_ Description: \_\_\_\_\_ Code: \_\_\_\_\_ Description: \_\_\_\_\_

For additional ICD-10 information, please visit [www.CVSspecialty.com/ICD10](http://www.CVSspecialty.com/ICD10)

**Patient Clinical Information:**  
 Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm  
 Concomitant Medications: \_\_\_\_\_  
 Additional Comments: \_\_\_\_\_

**Nursing:** Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary?  Yes  No  
 Injection training is not necessary. Date training occurred: \_\_\_\_\_  
 Reason:  MD office training patient  Pt already independent  Referred by MD office to alternate trainer

**5 PRESCRIPTION INFORMATION**

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)  DISPENSE AS WRITTEN (Date)

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