Cardiology Enrollment Form

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

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):

☐ Code: __________ Description: ______________________ ☐ Code: __________ Description: ______________________
☐ Code: __________ Description: ______________________ ☐ Code: __________ Description: ______________________

Patient Clinical Information:

Allergies: ______________________

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Please Complete Patient and Prescriber Information

Patient Name: ______________________ Patient DOB: ______________________

Prescriber Name: ______________________ Prescriber Phone: ______________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Arcalyst	NA	Please complete an Arcalyst Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.kiniksaoneconnect.com or by calling 1-833-KINIKSA (1-833-546-4572). Fax enrollment form to 781-609-7826.	Quantity: 0 Refills: 0
☐ Camzyos	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg	☐ Other: ______________ Note: Camzyos is only available through a restricted program called the Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program **because of the risk of heart failure due to systolic dysfunction.** Is the patient currently certified in the Camyzos REMS program? ☐ Yes ☐ No Is the prescriber currently certified in the Camyzos REMS program? ☐ Yes ☐ No Please complete the patient status form. The form may be accessed at CAMZYOSREMS.com. Once complete, fax this enrollment form to 888-626-7660.	Quantity: ________ (must be ≤ 35-day supply) Refills:________
☐ Dofetilide (generic for Tikosyn) ☐ Samsca (tolvaptan) ☐ Tikosyn (dofetilide) ☐ Tolvaptan (generic for Samsca) ☐ Vyndaqel (tafamidis meglumine) ☐ Vyndamax (tafamidis)	☐ Other: ________	☐ Other:______________	Quantity:________ Refills:________
RX #1	☐ 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 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.
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