Specialty Pharmacy Fertility Care Program Enrollment Form

CVS specialty®

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 CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____
Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cetrotide 0.25 mg Syringe	☐ Other: _____	Quantity: _____ Refills: _____
☐ Ganirelix 250 mcg/0.5mL	☐ Other: _____	Quantity: _____ Refills: _____
☐ Leuprolide 2 Week Kit	☐ Other: _____	Quantity: _____ Refills: _____
☐ Leuprolide Micro Dose ____ mcg / ____ mL	☐ Other: _____	Quantity: _____ Refills: _____
☐ Follistim AQ 300 IU Cartridge	☐ Other: _____	Quantity: _____ Refills: _____
☐ Follistim AQ 600 IU Cartridge	☐ Other: _____	Quantity: _____ Refills: _____
☐ Follistim AQ 900 IU Cartridge	☐ Other: _____	Quantity: _____ Refills: _____
☐ Follistim Pen	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F 450 IU MDV	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F 1050 IU MDV	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F RFF 75 IU Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 300 IU Pen	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 450 IU Pen	☐ Other: _____	Quantity: _____ Refills: _____
☐ Gonal-F RFF Rediject 900 IU Pen	☐ Other: _____	Quantity: _____ Refills: _____
☐ Menopur 75 IU Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ HCG Low Dose ____ Units / ____ mL Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ HCG 10,000 Unit Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Novarel 5,000 Unit Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Pregnyl 10,000 Unit Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Ovidrel 250 mcg / 0.5 mL	☐ Other: _____	Quantity: _____ Refills: _____
☐ Crinone 8% Gel	☐ Other: _____	Quantity: _____ Refills: _____
☐ Endometrin 100 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Prometrium _____ mg	☐ 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.

Specialty Pharmacy Fertility Care Program 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
☐ Progesterone Compounded Capsules ____ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Progesterone Suppositories ___ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Progesterone / Sesame Oil 50 mg / mL Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Progesterone(___) 50 mg / mL Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Delestrogen ____ mg / mL	☐ Other: _____	Quantity: _____ Refills: _____
☐ Syringe 1 mL only	☐ Other: _____	Quantity: _____ Refills: _____
☐ Syringe 3 mL only	☐ Other: _____	Quantity: _____ Refills: _____
☐ Syringe 3 mL 18 g 1.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Syringe 3 mL 22 g 1.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 18 g 1.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 22 g 1.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 25 g 1.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 25 g 5/8"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 27 g 0.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Needle 30 g 0.5"	☐ Other: _____	Quantity: _____ Refills: _____
☐ Insulin Syringe ___ mL	☐ Other: _____	Quantity: _____ Refills: _____
☐ Aspirin 81 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Azithromycin ____ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Cabergoline 0.5 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Citranatal _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Clomiphene 50 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Dexamethasone ____ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Doxycycline 100 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Estradiol ___ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Folic Acid 1 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Letrozole 2.5 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Methylprednisolone ____ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Prednisone ____ mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Prenatal Plus	☐ Other: _____	Quantity: _____ Refills: _____
☐ Z-Pak 250 mg #6 Tablets	☐ Other: _____	Quantity: _____ Refills: _____
☐ Climara 0.1 mg Patch	☐ Other: _____	Quantity: _____ Refills: _____
☐ Minivelle 0.1 mg Patch	☐ Other: _____	Quantity: _____ Refills: _____
☐ Vivelle DOT 0.1 mg Patch	☐ Other: _____	Quantity: _____ Refills: _____
☐ Heparin ____ units / mL Vial	☐ Other: _____	Quantity: _____ Refills: _____
☐ Lovenox ____ mg Syringes	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

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