Retinal Disorders/Ocular Specialty 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):

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 ______________________________

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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
☐ Beovu	Vial	**Induction dose:** ☐ Inject 6 mg monthly for the first three doses ☐ Other: ______ **Maintenance dose:** ☐ Inject 6 mg every 8 to 12 weeks ☐ Other: ______	Quantity: ______ Refills: ______
☐ Durysta	1 applicator	☐ To be injected by physician as directed ☐ Other: ______	Quantity: ______
☐ Eylea	☐ Vial ☐ PFS	☐ 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 ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment ☐ 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 ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) ☐ Other: ______	Quantity: ______ Refills: ______
☐ Iluvien	1 applicator	☐ To be injected by physician as directed ☐ Other: ______	Quantity: ______
☐ Lucentis	☐ 0.3 mg/0.05 mL single-dose PFS ☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose PFS ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: ______	Quantity: ______ Refills: ______
☐ Ozurdex	1 applicator	☐ To be injected by physician as directed ☐ Other: ______	Quantity: ______ Refills: ______
☐ Retisert	1 implant	☐ To be implanted by physician as directed ☐ Other: ______	Quantity: ______
☐ Susvimo	1 implant	☐ To be implanted by physician as directed ☐ Other: ______	Quantity: ______ Refills: ______
☐ Vabysmo	6 mg	☐ To be injected by physician as directed ☐ Other: ______	Quantity: ______ Refills: ______
☐ Visudyne	Vial	☐ To be infused by physician as directed ☐ Other: ______	Quantity: ______ Refills: ______
☐ Other: ______	Other: ______	Other: ______	Quantity: ______ Refills: ______
☐ Yutiq	0.18 mg (single dose implant)	☐ To be injected by physician as directed ☐ 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: ______ **Date:** ______	**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.

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