Sickle Cell Disease 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: _____
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/Caregier/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: _____
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):

☐ D57.1 Sickle-cell Disease ☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

Nursing: (for Adakveo)

Specialty pharmacy to coordinate home health nursing? ☐ Yes ☐ No Port? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Infusion ☐ Other _____

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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
☐ Adakveo	100 mg/10 ml single dose vial	Infuse _____ mg (5mg/kg) intravenously in normal saline (for total volume 100ml) over 30 minutes on week 0, week 2 and every 4 weeks thereafter. Patient weight: _____	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply Refills: _____
☐ Oxbryta	500 mg tablets	☐ Take 1500 mg orally once daily ☐ Other: _____	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply Refills: _____
☐ Oxbryta	300 mg tablets for oral suspension	Take _____ mg orally once daily. Patient weight: _____ Disperse tablets in room temperature, clear liquid before swallowing. Follow additional information provided for oral suspension. Do not swallow whole, cut, crush or chew tablets for oral suspension.	Quantity: ☐ 1-month supply ☐ 3-month supply ☐ 12-month supply 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.