Retinal Disorders/Ocular Specialty Enrollment Form

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

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 **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.

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