Acromegaly Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

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):

☐ E22.0 acromegaly and pituitary giantism ☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Bynfezia Pen (octreotide acetate) injection	2,500 mcg/mL	☐ Administer ____ mcg SC three times a day ☐ Other: _____	☐ 1 pen ☐ 2 pens ☐ Other: _____ Refills: _____
☐ Lanreotide Injection	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe	☐ Inject 90 mg (1 syringe) SC every 4 weeks ☐ Other: Inject _____ mg (1 syringe) SC every 4 weeks	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Sandostatin Injection Ampules	☐ 50 mcg/mL ☐ 100 mcg/mL ☐ 500 mcg/mL	☐ Administer ____ mcg SC three times a day ☐ Other: _____	Quantity: _____ Refills: _____
☐ Sandostatin Injection Multi-dose Vials	☐ 200 mcg/mL (5 ml) ☐ 1,000 mcg/mL (5 ml)	☐ Administer ____ mcg SC three times a day ☐ Other: _____	Quantity: _____ Refills: _____
☐ Sandostatin LAR Depot	☐ 10 mg vial kit ☐ 20 mg vial kit ☐ 30 mg vial kit	☐ Mix the contents of one vial with diluent and administer intragluteally every 4 weeks ☐ Other: _____	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Somatuline Depot	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe	☐ Inject 90 mg (1 syringe) SC every 4 weeks ☐ Other: Inject _____ mg (1 syringe) SC every 4 weeks	☐ 4-week supply ☐ 12-week supply Refills: _____
☐ Somavert	☐ 10 mg vial ☐ 15 mg vial ☐ 20 mg vial ☐ 25 mg vial ☐ 30 mg vial	☐ Inject _____mg SC once daily ☐ Other: _____	☐ ___ 10 mg vial kits ☐ ___ 15 mg vial kits ☐ ___ 20 mg vial kits 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.