

Cardiology Enrollment Form



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):

Code: _____ Description: _____ Code: _____ Description: _____
 Code: _____ Description: _____ Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

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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
<input type="checkbox"/> Arcalyst	NA	Please complete an Arcalyst Patient Enrollment and Consent form and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.kiniksaoneconnect.com or by calling 1-833-KINIKSA (1-833-546-4572). Fax enrollment form to 781-609-7826.	Quantity: 0 Refills: 0
<input type="checkbox"/> Camzyos	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg	<input type="checkbox"/> Other: _____ Note: Camzyos is only available through a restricted program called the Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program because of the risk of heart failure due to systolic dysfunction. Is the patient currently certified in the Camzyos REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber currently certified in the Camzyos REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No Please complete the patient status form. The form may be accessed at CAMZYOSREMS.com . Once complete, fax this enrollment form to 888-626-7660.	Quantity: _____ (must be ≤ 35-day supply) Refills: _____
<input type="checkbox"/> Dofetilide (generic for Tikosyn) <input type="checkbox"/> Samsca (tolvaptan) <input type="checkbox"/> Tikosyn (dofetilide) <input type="checkbox"/> Tolvaptan (generic for Samsca) <input type="checkbox"/> Vyndaqel (tafamidis meglumine) <input type="checkbox"/> Vyndamax (tafamidis)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
RX #1	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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