Specialty Pharmacy Services Enrollment Form

CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 800-237-2767

E-mail Referral To: customerservicefax@caremark.com

Health Alliance

6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: ☐Male ☐Female

E-mail: _____

Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____

State License #: _____ NPI #: _____

DEA #: _____

Group or Hospital: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ 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:

Please include diagnosis name and ICD-9:

ICD9:	Description

Additional Clinical Information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Height: _____ in/cm

Weight: _____ kg/lbs

Allergies: _____

Concomitant Medications: _____

Additional Comments: _____

Has patient received injection training? ☐ Yes ☐No ☐N/A

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

X _____

DISPENSE AS WRITTEN (Date)

X _____

PRODUCT SUBSTITUTION PERMITTED (Date)