

Specialty Pharmacy Services Enrollment Form



Fax Referral To: 800-323-2445

Phone: 800-237-2767

E-mail Referral To: customerservicefax@caremark.com



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:	Additional Clinical Information:										
Please include diagnosis name and ICD-9: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">ICD9:</th> <th style="width: 85%;">Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	ICD9:	Description									Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart Height: _____ in/cm Weight: _____ kg/lbs Allergies: _____ Concomitant Medications: _____ Additional Comments: _____ Has patient received injection training? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
ICD9:	Description										

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Patient is interested in patient support programs Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

6 X X

DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Specialty Pharmacy Services 030513