

# Specialty Pharmacy Services Enrollment Form



Fax Referral To: 1-800-323-2445

Phone: 1-866-638-8311

Email Referral To: [customerservicefax@caremark.com](mailto:customerservicefax@caremark.com)

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_  
Preferred Contact Method: Phone Text Email  
(to primary # provided below) (to cell # provided below) (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: \_\_\_\_\_ Home Cell Work  
Alternate Phone: \_\_\_\_\_ Home Cell Work  
DOB: \_\_\_\_\_ Gender: Male Female  
Email: \_\_\_\_\_  
Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
DEA #: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_  
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

#### Diagnosis (ICD-10):

Code: \_\_\_\_\_ Description: \_\_\_\_\_  
Code: \_\_\_\_\_ Description: \_\_\_\_\_

For additional ICD-10 information, please visit [www.CVSSpecialty.com/ICD10](http://www.CVSSpecialty.com/ICD10)

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm  
Concomitant Medications: \_\_\_\_\_  
Additional Comments: \_\_\_\_\_

**Nursing:** Specialty pharmacy to coordinate injection training/home health nurse visit as necessary?  Yes  No  
Injection training is not necessary. Date training occurred: \_\_\_\_\_  
Reason:  MD office training patient  Pt already independent  Referred by MD office to alternate trainer

### 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"/>				

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

**PHYSICIAN SIGNATURE REQUIRED**  
\_\_\_\_\_  
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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