Specialty Pharmacy Services Enrollment Form

CVS CAREMARK

Fax Referral To: 800-323-2445
Email Referral To: customerservicefax@caremark.com

Phone: 800-237-2767

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: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ 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

Diagnosis: (ICD-9 or ICD-10)

Please include diagnosis name and code:

ICD9 or ICD10	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

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6

PHYSICIAN SIGNATURE REQUIRED

X _____
DISPENSE AS WRITTEN (Date)

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)