Renal Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455 **Phone:** 1-808-254-2727
Address: 3375 Koapaka Street, Suite D105, Honolulu, HI 96819 **NCPDP:** 1203417

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Prescriber Name: _____Prescriber Phone: _____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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____
Diagnosis (ICD-10):
☐ Q61.2 Autosomal dominant polycystic kidney disease
☐ Code: _____ Description: _____ ☐ Code: _____ Description: _____
Allergies: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Filspari	NA	Please complete Filspari Patient Enrollment and Consent form; and indicate CVS Specialty as your preferred pharmacy provider. The form may be accessed at www.traveretotalcare.com or by calling 1-833-345-7727. Fax enrollment form to 888-381-0625. Note: Filspari is only available through a restricted program called the Filspari Risk Evaluation and Mitigation Strategy (REMS) Program **because of the risk of liver problems and serious birth defects.** Patient and prescriber forms can be accessed at Filsparirems.com.	Quantity: 0 Refills: 0
☐ Parsabiv	☐ 2.5 mg/0.5mL ☐ 5 mg/mL ☐ 10 mg/2mL	☐ Initiation: 5mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment ☐ Maintenance: _____ mg administered by intravenous bolus injection three times per week at end of hemodialysis treatment ☐ 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____	**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.

Renal Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Rivfloza	NA	All referrals must be sent through the manufacturer's HUB, NovoCare. Please visit www.novocare.com for more information.	Quantity: 0 Refills: 0
☐ Tolvaptan oral tablets for ADPKD	☐ 45 mg/15 mg 4 weekly blister packs 28 days' supply of 56 tablets	Take one 45 mg tablet by mouth upon waking and one 15 mg tablet by mouth 8 hours later	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____
	☐ 60 mg/30 mg 4 weekly blister packs 28 days' supply of 56 tablets	Take one 60 mg tablet by mouth upon waking and one 30 mg tablet by mouth 8 hours later	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____
	☐ 90 mg/30 mg 4 weekly blister packs 28 days' supply of 56 tablets	Take one 90 mg tablet by mouth upon waking and one 30 mg tablet by mouth 8 hours later	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____
☐ Tolvaptan oral tablets for ADPKD-Other Available Dosages	☐ 15 mg/15 mg 4 weekly blister packs 28 days' supply of 56 tablets	Take one 15 mg tablet by mouth upon waking and one 15 mg tablet by mouth 8 hours later	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____
	☐ 30 mg/15 mg 4 weekly blister packs 28 days' supply of 56 tablets	Take one 30 mg tablet by mouth upon waking and one 15 mg tablet by mouth 8 hours later	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____
☐ Tolvaptan oral tablets for ADPKD-Maintenance Dose	☐ 15 mg tablets ☐ 30 mg tablets	Other: _____	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____

Note: Tolvaptan for Autosomal Dominant Polycystic Kidney Disease (ADPKD) is only available through a restricted program

☐ Other: _____	☐ Strength: _____	Other: _____	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: _____

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