

# Retinal Disorders/Ocular Specialty Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

## 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/Guardian Name (Last, First): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ 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)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to: ☐ Patient ☐ Office ☐ Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

ICD-10 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Affected eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb./kg

**Durysta:** Can only be used once per lifetime per eye.

Has the patient received a prior **Durysta** implant in the treatment eye? ☐ Yes ☐ No

#### Iluvien:

Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

#### Susvimo:

Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo**:

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

Medication prescribed \_\_\_\_\_ Date prescribed \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

| MEDICATION                       | STRENGTH                                                      | DOSE & DIRECTIONS                                                                                                                                                                                                                                                                                                                                            | QUANTITY/REFILLS                  |
|----------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Beovu   | <input type="checkbox"/> Vial<br><input type="checkbox"/> PFS | <b>Induction dose:</b><br><input type="checkbox"/> Inject 6 mg monthly for the first three doses.<br><input type="checkbox"/> Inject 6 mg every 6 weeks for the first five doses.<br><input type="checkbox"/> Other: _____<br><b>Maintenance dose:</b><br><input type="checkbox"/> Inject 6 mg every 8 to 12 weeks.<br><input type="checkbox"/> Other: _____ | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Byooviz | <input type="checkbox"/> 0.5 mg single-dose vial              | <input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br><input type="checkbox"/> Other: _____                                                                                                                                                                          | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Other:  | <input type="checkbox"/> Strength: _____                      | <input type="checkbox"/> Dose: _____                                                                                                                                                                                                                                                                                                                         | Quantity: _____<br>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<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____             | May Substitute / Product Selection Permitted / Substitution Permissible<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____ |
| <b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" <b>ATTN: New York and Iowa providers</b> , 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.

# Retinal Disorders/Ocular Specialty 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                  |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Cimerli            | <input type="checkbox"/> 0.3 mg/0.05 mL single-dose vial<br><input type="checkbox"/> 0.5 mg/0.05 mL single-dose vial                                                                                                                       | <input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br><input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                              | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Durysta            | <input type="checkbox"/> 1 applicator                                                                                                                                                                                                      | <input type="checkbox"/> To be injected by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Quantity: _____                   |
| <input type="checkbox"/> Eylea              | <input type="checkbox"/> Vial<br><input type="checkbox"/> PFS                                                                                                                                                                              | <input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks.<br><input type="checkbox"/> Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment.<br><input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks.<br><input type="checkbox"/> Inject 2 mg (0.05 mL) every 4 weeks (monthly)<br><input type="checkbox"/> Pediatric - Inject 0.4mg (0.01mL)<br><input type="checkbox"/> Other: _____ | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Eylea HD           | <input type="checkbox"/> 8mg                                                                                                                                                                                                               | <input type="checkbox"/> Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by 8 mg every 8 to 16 weeks (2 to 4 months)<br><input type="checkbox"/> Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by every 8 to 12 weeks (2 to 3 months)<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                               | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Iluvien            | <input type="checkbox"/> 1 applicator                                                                                                                                                                                                      | <input type="checkbox"/> To be injected by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Quantity: _____                   |
| <input type="checkbox"/> Izervay            | <input type="checkbox"/> 2 mg single-dose vial (0.1 mL of 20 mg/mL solution)                                                                                                                                                               | <input type="checkbox"/> Prepare and administer 2 mg by intravitreal injection into each affected eye once monthly (approximately 28 days)<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                            | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Lucentis           | <input type="checkbox"/> 0.3 mg/0.05 mL single-dose PFS<br><input type="checkbox"/> 0.3 mg/0.05 mL single-dose vial<br><input type="checkbox"/> 0.5 mg/0.05 mL single-dose PFS<br><input type="checkbox"/> 0.5 mg/0.05 mL single-dose vial | <input type="checkbox"/> Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br><input type="checkbox"/> Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days)<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                              | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Ozurdex            | <input type="checkbox"/> 1 applicator                                                                                                                                                                                                      | <input type="checkbox"/> To be injected by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Retisert           | <input type="checkbox"/> 1 implant                                                                                                                                                                                                         | <input type="checkbox"/> To be implanted by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Quantity: _____                   |
| <input type="checkbox"/> Susvimo Refill Kit | <input type="checkbox"/> 1 Refill Kit                                                                                                                                                                                                      | <input type="checkbox"/> To be injected by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Vabysmo            | <input type="checkbox"/> 6 mg                                                                                                                                                                                                              | <input type="checkbox"/> To be injected by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Visudyne           | <input type="checkbox"/> Vial                                                                                                                                                                                                              | <input type="checkbox"/> To be infused by physician as directed<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Xdemvy             | <input type="checkbox"/> 0.25%                                                                                                                                                                                                             | <input type="checkbox"/> Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Other:             | <input type="checkbox"/> Strength: _____                                                                                                                                                                                                   | <input type="checkbox"/> Dose: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Quantity: _____<br>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<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____                     | May Substitute / Product Selection Permitted / Substitution Permissible<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____ |
| <b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " <b>ATTN: New York and Iowa providers,</b> 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.

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.