Retinal Disorders/Ocular Specialty Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

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
☐ Beovu	☐ Vial ☐ PFS	**Induction dose:** ☐ Inject 6 mg monthly for the first three doses. ☐ Inject 6 mg every 6 weeks for the first five doses. ☐ Other: _____ **Maintenance dose:** ☐ Inject 6 mg every 8 to 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Byooviz	☐ 0.5 mg single-dose vial	☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Strength: _____	☐ Dose: _____	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
Prescriber's Signature: _____ **Date:** _____

May Substitute / Product Selection Permitted / Substitution Permissible
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.

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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
☐ Cimerli	☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Durysta	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: _____	Quantity: _____
☐ Eylea	☐ Vial ☐ PFS	☐ 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. ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment. ☐ 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. ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) ☐ Pediatric - Inject 0.4mg (0.01mL) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Eylea HD	☐ 8mg	☐ 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) ☐ Inject 8 mg every 4 weeks (monthly) for the first 3 injections followed by every 8 to 12 weeks (2 to 3 months) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Iluvien	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: _____	Quantity: _____
☐ Izervay	☐ 2 mg single-dose vial (0.1 mL of 20 mg/mL solution)	☐ Prepare and administer 2 mg by intravitreal injection into each affected eye once monthly (approximately 28 days) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Lucentis	☐ 0.3 mg/0.05 mL single-dose PFS ☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose PFS ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: _____	Quantity: _____ Refills: _____
☐ Ozurdex	☐ 1 applicator	☐ To be injected by physician as directed ☐ Other: _____	Quantity: _____ Refills: _____
☐ Retisert	☐ 1 implant	☐ To be implanted by physician as directed ☐ Other: _____	Quantity: _____
☐ Susvimo Refill Kit	☐ 1 Refill Kit	☐ To be injected by physician as directed ☐ Other: _____	Quantity: _____ Refills: _____
☐ Vabysmo	☐ 6 mg	☐ To be injected by physician as directed ☐ Other: _____	Quantity: _____ Refills: _____
☐ Visudyne	☐ Vial	☐ To be infused by physician as directed ☐ Other: _____	Quantity: _____ Refills: _____
☐ Xdemvy	☐ 0.25%	☐ Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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