

Specialty Pharmacy Fertility Care Program Enrollment Form



Fax Referral To: 844-364-9364

Phone: 404-528-1728

Address: 2700 Northeast Expressway NE Suite B-800, Atlanta, GA 30345

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ Address: _____ City, State, ZIP: _____
 Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (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: _____ Alternate Phone: _____ 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 CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____
 Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cetrotide® 0.25 mg Syringe	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Ganirelix® 250 mcg/0.5mL	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Leuprolide 2 Week Kit	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Leuprolide Micro Dose _____ mcg / _____ mL	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Follistim® AQ 300 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Follistim AQ 600 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Follistim AQ 900 IU Cartridge	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Follistim Pen®	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F® 450 IU MDV	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F 1050 IU MDV	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F RFF 75 IU Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F RFF Rediject™ 300 IU Pen	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F RFF Rediject 450 IU Pen	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Gonal-F RFF Rediject 900 IU Pen	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Menopur® 75 IU Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> HCG Low Dose _____ Units / _____ mL Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> HCG 10,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Novarel® 5,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Pregnyl® 10,000 Unit Vial	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Ovidrel® 250 mcg / 0.5 mL	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Crinone® 8% Gel	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Endometrin® 100 mg	<input type="checkbox"/> Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Prometrium® _____ mg	<input type="checkbox"/> Other: _____	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

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ X _____

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 below, 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.

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Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION & STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Progesterone Compounded Capsules _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Progesterone Suppositories _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Progesterone / Sesame Oil 50 mg / mL Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Progesterone(_____) 50 mg / mL Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Delestrogen® _____ mg / mL	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Syringe 1 mL only	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Syringe 3 mL only	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Syringe 3 mL 18g 1.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Syringe 3 mL 22g 1.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 18 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 22 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 25 g 1.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 25 g 5/8"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 27 g 0.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Needle 30 g 0.5"	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Insulin Syringe _____ mL	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Aspirin 81 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Azithromycin _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cabergoline 0.5 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Citranatal® _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Clomiphene 50 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Dexamethasone _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Doxycycline 100 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Estradiol _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Folic Acid 1 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Letrozole 2.5 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Methylprednisolone _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone _____ mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prenatal Plus	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Z-Pak® 250 mg #6 Tablets	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Climara® 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Minivelle® 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Vivelle DOT® 0.1 mg Patch	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Heparin _____ units / mL Vial	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lovenox® _____ mg Syringes	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs

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