CVS CAREMARK | CAREMARK

SPECIALTY PHARMACY SERVICES
Enrollment Form

CAREMARKCONNECT®

TELEPHONE 1-800-237-2767 FAX 1-800-323-2445

1. PATIENT INFORMATION *To be completed by the patient*

Last Name | First Name | M.I.

Street Address | City

State | ZIP | Date of Birth (MM/DD/YYYY) | Sex (Check One) ☐Male ☐Female

Day Telephone # (+Area Code) | Night Telephone # (+Area Code) | Mobile Telephone # (+Area Code)

Parent/Guardian Name

INSURANCE INFORMATION

Primary/Medical Insurance | Secondary/Pharmacy Insurance

Cardholder Name (If Not Patient) | Cardholder Name (If Not Patient)

Subscriber ID # | Group/Policy # | Subscriber ID # | Group/Policy #

Insurance Telephone # (+Area Code) | Insurance Telephone # (+Area Code)

Employer | Medicaid #

ALTERNATE SHIPPING ADDRESS

Last Name | First Name | M.I.

Street Address | City | State | ZIP

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PRESCRIBER INFORMATION *To be completed by the physician and staff*

Prescriber's Last Name | Prescriber's First Name

Hospital/Clinic | Office Contact

Street Address

City | State | ZIP

Telephone # (+Area Code) | Fax # (+Area Code) | E-Mail Address

Prescriber's License # | DEA # | NPI #

UPIN# | Medicaid License #

75-PHC1937 10.07

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS: (ICD-9 CM Code Plus Description)

Date of Diagnosis / /

INJECTION TRAINING:

Injection Training Will Be/Has Been Conducted By the Physician's Office?

☐ Yes ☐ No Date / /

First Dose of Medication Will Be/Has Been Administered at Physician's Office?

☐ Yes ☐ No Date / /

Caremark to Refer/Coordinate Injection Training?

☐ Yes ☐ No Date / /

Rx

Patient Weight: _____ kg. OR _____ lbs.

Ancillary Supplies and Kits Provided as Needed for Administration.

☐ Enroll Patient in Manufacturer Support Program

Other Prescriber's Notes

Refill ☐ 12 Months ☐ Dispense As Written ☐ Refill ____ Times ☐ Substitution Allowed

Prescriber's Signature **Date**

Supervising Physician (If Applicable) **Date**

3. FAX COMPLETED FORM including copies of the patient's medical and prescription insurance cards (front and back) toll-free to CaremarkConnect® @ 1-800-323-2445

Thank you for choosing Caremark!