

# Specialty Pharmacy Services Enrollment Form



Fax Referral To: 800-323-2445  
 Email Referral To: customerservicefax@caremark.com

Phone: 800-237-2767

## 6 Simple steps to submitting a referral

### 1 PATIENT INFORMATION

*(Complete the following or include demographic sheet)*

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_  Home  Cell  Work  
 Alternate Phone: \_\_\_\_\_  Home  Cell  Work  
 DOB: \_\_\_\_\_ Gender:  Male  Female  
 E-mail: \_\_\_\_\_  
 Last Four of SS #: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
 State License #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 DEA #: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ 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

#### Diagnosis: (ICD-9 or ICD-10)

Please include diagnosis name and code:

ICD9 or ICD10	Description

#### Additional Clinical Information:

Therapy:  New  Reauthorization  Restart

Height: \_\_\_\_\_ in/cm

Weight: \_\_\_\_\_ kg/lbs

Allergies: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Has patient received injection training?  Yes  No  N/A

### 5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

6
X
X

DISPENSE AS WRITTEN \_\_\_\_\_ (Date)      PRODUCT SUBSTITUTION PERMITTED \_\_\_\_\_ (Date)