

Desferal (deferroxamine) 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/Legal 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)

Is the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

E83.11 – Hemochromatosis E83.111 – Hemochromatosis due to repeated red blood cell transfusions

E83.118 – Other hemochromatosis E83.119 – Hemochromatosis unspecified

D56.0 – Alpha thalassemia D56.1 – Beta thalassemia D56.8 – Other thalassemias

Other Code: _____ Description: _____

Patient Clinical Information:

Patient is: Naïve Non-naïve to Desferal (deferroxamine) therapy Please provide last infusion date(s): _____

Specialty pharmacy to coordinate nursing for home infusion? Yes No

Skilled Nurse to provide home infusion of medications per Homecare protocols and provide training on self-administration using pump. Yes No

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Desferal (deferroxamine)	<input type="checkbox"/> Prescriber acknowledges the following dosing concentration: per prescribing information in package insert, reconstitution with sterile water for injection results in a final concentration of 95 mg/mL of deferroxamine	<input type="checkbox"/> Infuse ____ mg (____ mL) subcutaneously via pump over (8-12 hours) ____ days a week	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: ____ vials Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

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.

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"/> Sterile Water	N/A	<input type="checkbox"/> Use as directed to reconstitute each vial of Desferal (deferroxamine) with per package insert.	Quantity: <input type="checkbox"/> QS mL of vials Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
PRE-MEDICATIONS:	NO PRE-MEDICATIONS		QUANTITY/REFILLS
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 12.5 mg/5 mL	<input type="checkbox"/> Take ___ mg by mouth 30-60 minutes prior to the infusion	Quantity: QS Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> LMX-4 Cream	4%	<input type="checkbox"/> Apply as directed 30-60 minutes prior to venous access to numb site as needed	Quantity: 1 tube or _____ Refills: _____
<input type="checkbox"/> Emla Cream	2.5%/2.5%	<input type="checkbox"/> Apply as directed 30-60 minutes prior to venous access to numb site as needed	Quantity: 1 tube or _____ Refills: _____
<input type="checkbox"/> Other	Other: _____	Other: _____	<input type="checkbox"/> PRN <input type="checkbox"/> Other: _____ Refills: _____
ACUTE INFUSION REACTION ORDERS:	NO RESCUE MEDICATIONS		QUANTITY/REFILLS
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50 mg/mL (1 mL/vial)	<input type="checkbox"/> Administer ___ mg slow IV push as needed for adverse reaction	Quantity: QS Refills: _____
<input type="checkbox"/> Epinephrine Auto-Injector (2-pack)/box	<input type="checkbox"/> 0.3 mg/ 0.3 mL	<input type="checkbox"/> Inject 0.3 mg intramuscularly as needed for anaphylactic reaction. May repeat in 5-15 minutes as needed	Quantity: One 2-pack Refills: _____
<input type="checkbox"/> Other	Other: _____	Other: _____	<input type="checkbox"/> PRN <input type="checkbox"/> Other: _____ Refills: _____

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