Desferal (deferoxamine) 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/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 (deferoxamine) 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
☐ Desferal (deferoxamine)	☐ 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 deferoxamine**	☐ Infuse ____ mg (___ mL) subcutaneously via pump over (8-12 hours) ___ days a week	Quantity: ☐ 30-day supply ☐ Other: ____ vials Refills: ☐ 1 year ☐ 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.

CVS specialty® Desferal (deferoxamine) Enrollment Form
Nursing Medications

Coram® CVS specialty® infusion services

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

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