CVS CAREMARK | CAREMARK

SPECIALTY PHARMACY SERVICES
Enrollment Form

PEDIATRIC ENDOCRINE
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-PHC2454 01.08

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

☐ 253.2 Panhypopituitarism ☐ 253.3 Isolated Growth Hormone Deficiency
☐ 253.7 Latrogenic Pituitary Disorder ☐ 259.1 Precocious Puberty
☐ 585 Chronic Renal Failure/Insufficiency ☐ 758.6 Gonadal Dysgenesis (Turner Syndrome)
☐ 759.81 Prader-Willi Syndrome
☐ 783.43 Short Stature ☐ Idiopathic Short Stature ☐ Small for Gestational Age
☐ Other (Please Indicate ICD-9 CM Code & Description) _____

PERTINENT MEDICAL HISTORY: FOR PEDIATRIC PATIENTS, PLEASE INCLUDE A GROWTH CHART.

Visit Date / / Height _____ Weight _____ Annualized Growth Velocity _____
Bone Age & Date _____/_____ ☐ Advanced ☐ Delayed ☐ Normal
Allergies _____ IGF-1 _____ BP3 _____
Tanner Stage _____ Next Clinic Visit _____
Has Patient Previously Been on Growth Hormone? ☐ Yes ☐ No
If Yes, Start Date & Product: _____/_____
Does This Patient Have an ☐ Active/ ☐ History of Tumor/Malignancy? ☐ Yes ☐ No
If Yes, How Long Has Regrowth Been Absent? _____ Years
Other History _____

PROVOCATIVE TEST RESULTS:

Test #1 ☐ N/A

Agent	Date	Peak Value	Units

Test #2 ☐ N/A

Agent	Date	Peak Value	Units

INJECTION TRAINING:

Injection Training Will Be/Has Been Conducted By the Physician's Office? ☐ Yes ☐ No Date: / /
I Would Like Caremark to Coordinate Injection Training? ☐ Yes ☐ No

Rx

☐ **Humatrope®** ☐ 5 mg Vial ☐ 6 mg ☐ 12 mg ☐ 24 mg Cartridge ☐ HumatroPen®
☐ **Nutropin®** ☐ 5 mg ☐ 10 mg Vial
☐ **Nutropin AQ®** ☐ 10 mg Vial ☐ 10 mg Pen ☐ 10 mg Cartridge ☐ 20 mg Pen ☐ 20 mg Cartridge
☐ **Norditropin®** ☐ 5 mg ☐ 15 mg Cartridge ☐ 5 mg ☐ 15 mg NordiPen®
☐ 5 mg ☐ 10 mg ☐ 15 mg Nordiflex®
☐ **Genotropin®** ☐ 1.5 mg ☐ 5.8 mg ☐ 13.8 mg Cartridge/Intra-Mix® Miniquick® ____ mg
☐ Pen 5 ☐ Pen 12
☐ **Saizen®** ☐ 5 mg ☐ 8.8 mg Vial ☐ cool.click™ ☐ 8.8 mg click.easy™ Cartridge ☐ one.click™
☐ **Tev-Tropin™** ☐ 5 mg Vial ☐ Inject-Ease®
☐ **Geref® Diagnostic** ☐ 50 mcg Vial
☐ **Lupron® Depot PED** ☐ 7.5 mg ☐ 11.25 mg ☐ 15 mg Kit
☐ **Other** _____

Ancillary Supplies and Kits Provided as Needed for Administration.

Sig | **Quantity**

☐ Refill ____ Months ☐ Dispense As Written ☐ Substitution Allowed

Prescriber's Signature | **Date**

PHYSICIAN SPECIALTY: ☐ Endocrinologist ☐ Other (Specify) _____

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!