CAREMARK
It all starts with care®

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

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

Date of Birth (MM/DD/YYYY) | Social Security # | Sex (Check One) ☐M ☐F

Parent/Guardian Name

INSURANCE INFORMATION

Primary/Medical Insurance | Secondary/Pharmacy Insurance

Cardholder Name & ID # (If Not Patient) | Cardholder Name & ID # (If Not Patient)

Group/Policy # | 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. PHYSICIAN 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 1006

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 ☐ Refill ____ Times

☐ Dispense As Written ☐ Substitution Allowed

Prescriber's Signature **Date**

3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.

Thank you for choosing Caremark!