CAREMARK
It all starts with care

SPECIALTY PHARMACY SERVICES
Enrollment Form

ALPHA$_1$ PROTEINASE INHIBITOR DEFICIENCY

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.

75-PHC3858 1006

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 #

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

☐ 277.6 (Congenital Emphysema) Alpha$_1$-Antitrypsin Deficiency

PERTINENT MEDICAL HISTORY:

Height _____ Weight _____ As of Date / /

Allergies _____

Therapy Start Date / / Length of Therapy _____

Deliver Product To: ☐ Physician's Office ☐ Patient's Home ☐ Other _____

If Administered in Home, Should Caremark Refer/Coordinate Nursing for Administration? ☐ Yes ☐ No

Recommended Agency? _____

Rx

☐ **Aralast™** **Date** / /

Dosage _____ mg/kg Body Weight/Once Weekly

Directions _____

I.V. Access _____

Flushing Protocol _____

EpiPen® ☐ Yes ☐ No

Ancillary Supplies and Kits Provided as Needed for Administration.

Sig | **Quantity**

☐ Refill ____ Months

☐ 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!