CAREMARK
It all starts with care®

SPECIALTY PHARMACY SERVICES
Enrollment Form

MACULAR DEGENERATION

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-PHC3740 1006

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

(Please Check With the Patient's Insurer to Select the Appropriate ICD-9 Code)

ICD-9 Code

- ☐ 362.16 Choroidal Neovascularization
- ☐ 362.50 Macular Degeneration (Senile)
- ☐ 362.52 Exudative Senile Macular Degeneration
- ☐ Other ICD9 _____

Expected Date of Injection / /

Rx

Lucentis™ (Ranibizumab Injection)

- ☐ Lucentis 0.5 mg/0.05 ml Vial

Sig: 0.5 mg by Intravitreous Injection Into Affected Eye Every 4 Weeks

☐ Refill ____ Times ☐ Dispense As Written

Optional Dosing Schedule After 4 Monthly Injections

Sig: 0.5 mg by Intravitreous Injection Into Affected Eye Every 3 Months

☐ Refill ____ Times ☐ Dispense As Written

Macugen® (Pegaptanib Sodium Injection)

- ☐ Macugen 0.3 mg Pre-Filled Syringe

Sig: 0.3 mg by Intravitreous Injection Into Affected Eye Every 6 Weeks

☐ Refill ____ Times ☐ Dispense As Written

Visudyne® (Verteporfin for Injection)

- ☐ Visudyne 15 mg Vial

Sig: To Be Infused by Physician As Directed

☐ Refill ____ Times ☐ Dispense As Written

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!