# CVS Caremark Enrollment Form For North Carolina ADAP

**600 Penn Center Blvd, Pittsburgh, PA 15235**
**Fax Referral To: 888-772-3244**
**Phone: 800-465-7333**

**Date:** _____ **Needs by Date:** _____

**Ship to:** ☐ **Patient** ☐ **Office** ☐ **Other:** _____

## PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Date of Birth: _____ Gender: _____

## PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

## INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

**Primary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
**Secondary Insurance:** Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

## STATEMENT OF MEDICAL NECESSITY

**Diagnosis:**

_____
_____
_____

• Date of Diagnosis: _____

**Lab Data/Allergies/Additional Comments/ Concomitant Medications:**

_____
_____
_____

**Injection Training/Home Health Coordination:**

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

## PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
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_____ (Date) _____ (Date)
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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