

CAREMARK ENROLLMENT FORM

Section 1 should be completed by the patient. Section 2 should be completed by the physician and staff. Section 3 provides the fax number to send the completed form to.

CAREMARKCONNECT®

TEL (800) 237-2767

FAX (800) 323-2445



PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____
 Street Address _____ City _____ State _____ Zip Code _____
 Day Telephone (+Area Code) _____ Night Telephone (+Area Code) _____ M F
 Date of Birth _____ Social Security Number _____ Sex (✓One) _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____
 Cardholder Name & Social Security Number (If Not Patient) _____ Cardholder Name & Social Security Number (If Not Patient) _____
 Group/Policy Number _____ Group/Policy Number _____
 Insurance Telephone Number (+Area Code) _____ Insurance Telephone Number (+Area Code) _____
 Employer _____ Medicaid Number _____

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. In signing below, you indicate and acknowledge that the information you provided above is true and correct.

Patient Signature: _____ Date: _____

CAREMARK Thank you for choosing Caremark!
It all starts with care™

PHC1934-042-003BL



PHYSICIAN INFORMATION

Prescriber's Name _____ Hospital/Clinic _____ Office Contact _____
 Address _____ City/State/Zip _____ Telephone Number (+Area Code) _____
 Prescriber's License Number _____ DEA Number _____ Fax Number (+Area Code) _____
 Supervising Physician's Name (If Required for Mid-Level Practitioner) _____ License Number _____

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? Y N Date: _____
 First dose of medication will be/has been administered at physician's office? Y N Date: _____
 Caremark to refer/coordinate injection training? Y N

Rx

Patient Weight: _____ kg. OR _____ lbs.

Ancillary supplies as needed for injection.

Enroll patient in manufacturer support program

Other Prescriber's Notes:

Prescriber's Signature: _____ Refill: 12 months Refill _____ times
 Dispense As Written Substitution Allowed

Physician's Signature (If required for Medical Necessity)

Date: Unless otherwise indicated, date used will be date of fax transmission.



FAX COMPLETED FORM TO CAREMARKCONNECT® AT 1 (800) 323-2445

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