

Nuzyra Enrollment Form

Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com

Address:City, State, ZIP Code: Gender:MalePernale Preferred Contact Methods:Phone (to primary # provided below)Text (to cell # provided below)Enail (to email provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, e mai/or text messages from CVS Specialty* About you prescription(s), account, and health care. Standard data rates apply. Message frequency If unable to contact via text or email. Specialty Pharmacy will attempt to contact by phone. Primary Phone:Alternate Phone:Primary Language:Primary L			Six Simple S	Steps to Su	bmitting a Re	eferral		
Gender: Male Formale Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Mark: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, e and/or text messages from CVS Specially Pharmacy will attempt to contact by phone. Primary Phone:	PATIENT	INFORMATI	ON (Complete or include	e demograpi	hic sheet)			
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Parent/Caregiver/Legal Guardian Name (Last, First):Relationship to patient: PRESCRIBER INFORMATION Please Complete Patient and Prescriber Information Patient Name:Patient DOB:Patient Phone: Prescriber Name:Patient DOB:Patient Phone: Prescriber Name:Patient DOB:Patient Phone: State License #:NPI #:DEA #: Group or Hospital:Address:Contact's Phone: Group or Hospital:Contact's Phone: Group or Hospital:								
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Patient Name:Patient DOB:Patient Phone:Prescriber Phone:Prescriber Phone: Prescriber Name:Prescriber Phone: State License #:NPI #:DEA #: Group or Hospital:Address: Contact Person:Contact's Phone: INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and I DIAGNOSIS AND CLINICAL INFORMATION Needs by Date:Ship to:] Patient] Office] Other: Diagnosis (ICD-10): J18.9 PneumoniaLO8.9 Local infection of the skin and subcutaneous tissue Other Code: Description: Patient Clinical Information: Allergies: Height: in/cm Weight:b/kg PRESCRIPTION INFORMATION MEDICATION DOSE DIRECTIONS QUANTITY/REFILLS Quantity: Ge-count pack Other: Refills: N/A Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for admin CPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) Tolspense As Writter / Prand Medically Necessary / Do Not Substitute / No Substitute / Product Selection Permitted / SUM // May Not Substitute / Not Substitute / Not Substitute / Not Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitu				Patient an	d Prescriber	Information		
Prescriber Name:	Patient Name:							
Diagnosis (ICD-10):								
City, State, ZIP Code:				NPI #:		DEA #:		
Contact's Phone:	Group or Hospi	tal:			Address:			
	City, State, ZIP	Code:		Fax				
DIAGNOSIS AND CLINICAL INFORMATION Needs by Date:	Contact Person	:		Contact's Phone:				
DIAGNOSIS AND CLINICAL INFORMATION Needs by Date:	3 INSURAN	ICE INFORM	ATION Please fax copy	of prescripti	on and insuranc	e cards with this form, if a	vailable (front and back)	
Allergies:	Diagnosis (ICD-10): J18.9 Pneumonia Other Code:		L08.9 Loc	L08.9 Local infection of the skin and subcutaneous tissue				
Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitute / Product Selection Permitted / Substitution Permissible				Height [.]	in/cm	Weight [.]	lb/ka	
MEDICATION DOSE DIRECTIONS QUANTITY/REFILLS MEDICATION DOSE DIRECTIONS Quantity: Generative Nuzyra 150 mg Other: Generative Generative Generative Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for admin Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for admin Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitute / No Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitution Permissible May Substitute / Product Selection Permitted / Substitution Permissible	_			i loigita j				
Image: Nuzyra 150 mg Other:							NTITY/REFILLS	
Berescriber Signature Required (Stamp Signature Not Allowed) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute May Substitute / Product Selection Permitted / Substitution Permissible	_					Quantity:	ck	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute / Product Selection Permitted / Substitution Permissible	Patient is interes	sted in patient suppor	t programs STAMP SIG	NATURE NOT A	LLOWED Ar	ncillary supplies and kits provide	ed as needed for administration	
DAW / May Not Substitute Substitution Permissible		6 PRESCRI	BER SIGNATURE RE	QUIRED (STAMP SIG	NATURE NOT ALLO	WED)	
	DAW / May Not Subs	titute		Sub		nissible	Date:	
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic	CA, MA, NC & PR: Int	erchange is mandated u	nless Prescriber writes the words " No	Substitution"	L ATT	N: New York and Iowa providers	, please submit electronic prescripti	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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