Non-Small Cell Lung Cancer Medications Enrollment Form

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________________ DOB: ______________ Gender: ☐ Male ☐ Female

Address: ______________________________ City, State, ZIP Code: ______________________

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: ______________________________ Alternate Phone: ______________________

Email: ______________________________ Last Four of SSN: ________ Primary Language: ______________

Parent/Caregiver/Guardian Name (Last, First): ______________________ Relationship to Patient: ______________________

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ________________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________________

Diagnosis (ICD-10):

☐ Code: ______ Description ______________________ ☐ Code: ______ Description ______________________

☐ Code: ______ Description ______________________ ☐ Code: ______ Description ______________________

Patient Clinical Information:

Allergies: ______________________________ Weight: _____lb/kg Height: _____in/cm BSA: ____ m^2

Biomarker(s): ☐ ALK+ ☐ BRAF V600E ☐ EGFR + ☐ EGFR/T790M+ ☐ KRAS G12C+ ☐ METex14+ ☐ NTRK1/2/3+ ☐ RET+ ☐ ROS1+ ☐ PD-L1 <1% ☐ PD-L1 ≥1%-49% ☐ PD-L1 ≥ 50% ☐ No actionable molecular marker

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
☐ Avastin	☐ 100 mg/4 mL ☐ 400 mg/16 mL	☐ 15 mg/kg IV every three weeks ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Alecensa	150 mg	☐ 4 capsules PO twice daily #240 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Augtyro	40 mg	☐ 4 capsules PO once daily for 14 days, then increase to 4 capsules twice daily thereafter ☐ 4 capsules PO twice daily #240 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Braftovi	75 mg	☐ 6 capsules PO once daily #180 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Cyramza	☐ 100 mg/10 mL ☐ 500 mg/50 mL	☐ 10 mg/kg IV once every two weeks ☐ 10 mg/kg IV once every three weeks ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Enhertu	100 mg	☐ 5.4 mg/kg IV once every three weeks ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Gavreto	100 mg	☐ 4 capsules PO once daily #120 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Imfinzi	☐ 120 mg/2.4 mL ☐ 500 mg/10 mL	☐ 10 mg/kg IV every 2 weeks ☐ 1500 mg IV every 4 weeks ☐ 20 mg/kg IV every 3 weeks for 4 cycles then every 4 weeks ☐ 1,500 mg IV every 3 weeks for 4 cycles then every 4 weeks ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Imjudo	☐ 25 mg/1.25 mL ☐ 300 mg/15 mL	☐ 75 mg IV every 3 weeks for 4 cycles and a 5th dose at week 16 ☐ 1mg/kg IV every 3 weeks for 4 cycles and a 5th dose at week 16 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Iressa	250 mg	☐ 1 tablet PO once daily #30 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Keytruda	100 mg/4 mL	☐ 200 mg IV every three weeks ☐ 400 mg IV every six weeks ☐ Other: ______________________	Quantity:________ Refills:__________

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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Non-Small Cell Lung Cancer Medications Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: ______________________ Patient DOB: ____________ Patient Phone Number: ____________________

Prescriber Name: ______________________ Prescriber Phone: ______________________________

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
☐ Libtayo	350 mg/7 mL	☐ 350 mg IV every three weeks ☐ Other: ____________	Quantity:________ Refills:__________
☐ Lorbrena	☐ 25 mg ☐ 100 mg	☐ 1 tablet PO once daily #30 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Lumakras	120 mg	☐ 8 tablets PO once daily #240 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Mekinist	☐ 0.5 mg ☐ 2 mg	☐ 1 tablet PO once daily #30 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Mektovi	15 mg	☐ 3 tablets PO twice daily #180 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Opdivo	☐ 40 mg/4 mL ☐ 100 mg/10 mL ☐ 120 mg/12 mL ☐ 240 mg/24 mL	☐ 240 mg IV every two weeks ☐ 480 mg IV every four weeks ☐ 360 mg IV every three weeks ☐ 3 mg/kg IV every two weeks ☐ Other: ____________	Quantity:________ Refills:__________
☐ Retevmo	☐ 40 mg ☐ 80 mg	☐ 2 capsules PO twice daily #120 ☐ 3 capsules PO twice daily #180 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Rozlytrek	☐ 100 mg ☐ 200 mg	☐ 3 capsules PO once daily #90 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Rybrevant	350 mg/7 mL	☐ 1050 mg IV once weekly for 4 weeks then every 2 weeks starting at week 5 ☐ 1400 mg IV once weekly for 4 weeks then every 2 weeks starting at week ☐ Other: ____________	Quantity:________ Refills:__________
☐ Tabrecta	☐ 150 mg ☐ 200 mg	☐ 2 tablets PO twice daily #112 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Tafinlar	☐ 50 mg ☐ 75 mg	☐ 2 capsules PO twice daily #120 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Tagrisso	☐ 40 mg ☐ 80 mg	☐ 1 tablet PO once daily #30 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Tarceva	☐ 25 mg ☐ 100mg ☐ 150 mg	☐ 1 tablet PO once daily #30 ☐ 3 tablets PO once daily #90 ☐ Other: ____________	Quantity:________ Refills:__________
☐ Tecentriq	☐ 840 mg/14 mL ☐ 1,200 mg/20 mL	☐ 1,200 mg IV every two weeks ☐ Other: ____________	Quantity:________ Refills:__________
☐ Vitrakvi	☐ 25 mg ☐ 100 mg	☐ 1 capsule PO twice daily #60 ☐ Other: ____________	Quantity:________ Refills:__________

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Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ____________ Patient Phone Number: ____________________

Prescriber Name: ____________________________ Prescriber Phone: ____

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
☐ Vizimpro	☐ 15 mg ☐ 45 mg ☐ 30 mg	☐ 1 tablet PO once daily #30 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Xalkori	☐ 200 mg ☐ 250 mg	☐ 1 capsule PO twice daily #60 ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 1 mg/kg IV every six weeks ☐ Other: ______________________	Quantity:________ Refills:__________
☐ Zykadia	150 mg	☐ 3 tablets PO once daily #90 ☐ Other: ______________________	Quantity:________ Refills:__________
RX 1	☐ Other: __________	☐ Other: ______________________	Quantity:________ Refills:__________
RX 2	☐ Other: __________	☐ Other: ______________________	Quantity:________ Refills:__________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: ______________________ Date: ________**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: ______________________ Date: ______**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________ **ATTN: New York and Iowa providers,** please submit electronic prescription

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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