## Oncology Dermatology Medication Enrollment Form Medications A-O

(Braftovi, Cotellic, Erivedge, Keytruda, Mekinist, Mektovi, Odomzo, Opdivo, Opdualag)



Fax Referral To: 1-888-280-1191 OR 787-759-4161 Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 Phone: 1-888-280-1190 OR 787-759-4162

NCPDP: 4026325

		mple Steps to Subm	itting a Referral				
	MATION (Complete or includ	• .					
	N (Complete or include dem	• .		1			
			Gender: Male	] Female			
ddress:		City, St	tate, ZIP Code:	<del></del> ,			
		•	cell # provided below) 0 Email (to email provid	ed below)			
			lty Pharmacy will attempt to contact by phone.				
		Alterr	nate Phone:				
nail:	:(O	Last Four of SSI	N: Primary Language:				
		irst):F	Relationship to minor:	<del></del>			
PRESCRIBER INF	ORMATION		0				
escriber's Name:	DEA #.	way and baseliade	State License #:				
PI #:	_ DEA #: GI	roup or Hospital:	Chata ZID Code:				
acress:	Forg	Contact Person:	State, ZIP Code: Contact's Phone:				
INCLIDANCE INC	rax	Contact Person	Contact's Priorie.				
			surance cards with this form, if available (fror				
	CLINICAL INFORMATI	ON Needs by Date:	Ship to: Patient Office Other:				
iagnosis (ICD-10):							
	ption		Code: Description				
	ption		Code: Description				
	mation: Allergies:	We	ight:lb/kg Height:in/cm				
PRESCRIPTION I	NFORMATION						
<b>DRUG NAME</b>	STRENGTH	SIC	G/DIRECTIONS QUA	ANTITY/REFILL			
	П <b>го</b>	450 mg PO once daily i	in combination with Mektovi 45 mg PO twice daily				
☐ Braftovi	☐ 50 mg ☐ 75 mg	in combination with Erbitux	Quantity:				
	□ 75 mg	Refills:					
		☐ 3 tablets PO once daily	3 tablets PO once daily days 1-21, off 7 days. Recycle every 28 days.  Other:				
☐ Cotellic	20 mg						
		1 capsule PO once daily		Quantity:			
☐ Erivedge	150 mg	Other:	,	Refills:			
			Quantity:				
☐ Keytruda	100 mg/4 mL 200 mg IV every 3 weeks 400 mg IV every 6 weeks						
	100 mg/4 mL Other: Re						
	☐ 2 mg	1 tablet PO once daily Quantity					
	☐ 0.5 mg			Refills:			
☐ Mektovi	15 mg	45 mg PO twice daily ir	Quantity: Refills:				
	9	Other:					
Odomzo	200 mg	1 capsule PO once daily	Quantity:				
☐ Odomizo	2001119	Refills:					
	☐ 40 mg/4 mL	240 mg IV every two w	reeks 480 mg IV every four weeks	Quantity:			
Opdivo	100 mg/10 mL		reeks 🗌 6mg/kg IV every four weeks	Refills:			
<u></u> Орагуо	240 mg/24 mL	1 mg/kg IV every 3 wee					
		Other:					
□Opdualag				Quantity:			
(nivolumab and	240 mg-80 mg/20 mL	The state of the s					
relatimab-rmbw)		Refills:					
Patient is interested in	n patient support programs STA	MP SIGNATURE NOT ALLOWE	Ancillary supplies and kits provided as needed for add	ministration			
8	PRESCRIBER SIGNAT	URE REQUIRED (ST	AMP SIGNATURE NOT ALLOWED)				
		-	<u> </u>				
"Dispense As Written" / DAW / May Not Substitut	Brand Medically Necessary / Do Not te	Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible				
,	•						

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.

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

ATTN: New York and Iowa providers, please submit electronic prescription

## Oncology Dermatology Medication Enrollment Form

## **Medications P-Z**

(Poteligeo, Tafinlar, Tecentriq, Yervoy, Zelboraf, Zolinza)

Poteligeo   20 mg/5 mL		Ple	ase Complete Pa	tient an	d Prescriber Information			
PRESCRIPTION INFORMATION   SIG/DIRECTIONS   QUANTITY/REF     Poteligeo   20 mg/5 mL	Patient Name	e:		Patient DOB:				
DRUG NAME   STRENGTH   SIG/DIRECTIONS   QUANTITY/REF     Poteligeo   20 mg/5 mL   1 mg/kg IV Days 1, 8, 15, 22 x 1 cycle   1 mg/kg IV every 2 weeks   Quantity: Refills:     Tafinlar   50 mg   2 capsules PO twice daily   Quantity: Refills:     Tecentriq   840 mg/14 mL   840 mg IV every 2 weeks   Quantity: Refills:     Tecentriq   840 mg/14 mL   3 mg/kg IV every 3 weeks x 4 doses   Quantity: Refills:     Tecentriq   50 mg/10 mL   10 mg/kg IV every 3 weeks x 4 doses   Quantity: Refills:     Teleboraf   240 mg   4 tablets PO twice daily   Quantity: Refills:     Zelboraf   240 mg   4 tablets PO twice daily   Quantity: Refills:     Zolinza   100 mg   4 capsules PO once daily   Quantity: Refills:     Rx 1   Other:   Other:   Quantity: Refills:     Rx 2   Other:   Other:   Quantity: Refills:     Rx 3   Ondansetron   Other:   Quantity: Refills:     Prescriptions   Promethazine   Other:   Quantity: Refills:     Promethazine   Other:   Quantity: Refills:     Promethazine   Other:   Prand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitution Permissible	Prescriber Na	ame:	Prescriber Phone:					
Deteligeo   20 mg/5 mL	5 PRESCRIP	TION INFORMATIO	N					
Poteligeo   20 mg/5 mL	DRUG NAME	STRENGTH		SIG/	DIRECTIONS	QUANTITY/REFILLS		
Tariniar	Poteligeo	20 mg/5 mL	1 mg/kg IV every 2	Quantity: Refills:				
Tecentriq	Tafinlar	1 = °	· = '	Quantity: Refills:				
Yervoy	Tecentriq	840 mg/14 mL	I — ·	weeks		Quantity:		
Zelborar	☐ Yervoy		10 mg/kg IV every 10 mg/kg IV every	Quantity: Refills:				
Zolinza   100 mg     4 capsules PO once daily     Quantity: Refills:	Zelboraf	240 mg				Quantity: Refills:		
Rx 1	Zolinza	100 mg	100 mg			Quantity: Refills:		
Refills:	PRESCRIPTIO	NS DRUG NAM	ME/STRENGTH		SIG/DIRECTIONS	QUANTITY/REFILLS		
Rx 2 Other: Other: Other: Quantity: Refills: Quantity: Refills: Refills: May Substitute / Product Selection Permitted / Substitution / Substitution Permissible	Rx 1	☐ Other:		Other:		Quantity: Refills:		
Rx 3 Ondansetron Other: Other: Refills: Refills: Refills: May Substitute / Product Selection Permitted / Substitution / Substitution Permissible	Rx 2	Other:		Other:		Quantity:		
6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  ispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / W / May Not Substitute  May Substitute / Product Selection Permitted / Substitution Permissible	Rx 3			Other:		Quantity:		
ispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / W / May Not Substitute   May Substitute / Product Selection Permitted / Substitution Permissible	Patient is interest	ted in patient support progra	ıms STAMP S	IGNATURE N	NOT ALLOWED Ancillary supplies and kits	provided as needed for administration		
W / May Not Substitute Substitution Permissible		6 PRESCRIBER	SIGNATURE REQ	UIRED (S	STAMP SIGNATURE NOT A	LLOWED)		
rescriber's Signature:Date:	AW / May Not Substitute				Substitution Permissible			
	rescriber's Sigi	nature:	Date:		Prescriber's Signature:	Date:		

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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