

# Oncology Supportive Therapy Enrollment Form

Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com Phone: 1-800-237-2767

### Six Simple Steps to Submitting a Referral

# PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name:	DOB:	Gender: 🗌 Male 🔲 Female
Address:	City, State, ZIP	Code:
Preferred Contact Methods:  Phone (to primar	y # provided below) 🗌 Text (to cell # provi	ded below) 🗌 Email (to email provided below)
Note: Carrier charges may apply. If unable to contact	via text or email, Specialty Pharmacy will at	tempt to contact by phone
Primary Phone:	Alternate Pho	one:
Email:	Last Four of SSN:	Primary Language:
If Minor, Parent/Caregiver/Guardian Name (La	st, First): <b>Relatio</b> r	nship to minor:

## **2 PRESCRIBER INFORMATION**

Prescriber's Name: _			State License #:		
NPI #:	DEA #:	Group or Hospital:			
Address:			_ City, State, ZIP Code:		
Phone:	Fax:	Contact Person	· · · · · · · · · · · · · · · · · · ·	Contact's Phone:	

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 🗌 Off	fice 🗌 Other:	
Diagnosis (ICD-10):			
Code:	_ Description:		
Code:	_ Description:		
Code:	_ Description:		
Patient Clinical Inform	ation:		
Allergies:		Height:in/cm	Weight:lb/kg

# Oncology Supportive Therapy

# **Enrollment Form**

	Please Co	mplete Patient and Prescriber Inform	nation	
Patient Name:		Patient DOB:	Patient Phone:	
Prescriber Nam	rescriber Name:			
<b>5 PRESCRI</b>	PTION INFORMATION			
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QU	ANTITY/REFILLS
Aranesp	Single-dose Vials:         25 mcg       40 mcg         60 mcg       100 mcg         150 mcg       200 mcg         300 mcg       500 mcg         Single-dose Prefilled Syringes:         10 mcg       25 mcg         40 mcg       60 mcg         100 mcg       15 mcg         200 mcg       300 mcg         500 mcg       500 mcg         100 mcg       150 mcg         100 mcg       300 mcg         500 mcg       300 mcg	<ul> <li>Inject the entire contents of vial/syringe on (Circle: IV or SC)</li> <li>Inject the entire contents of vial/syringe evolocity (Circle: IV or SC)</li> <li>Other:</li></ul>	ery 3 weeks	Quantity: Refills:
Epogen OR Procrit	<ul> <li>2,000 u/mL (SDV)</li> <li>3,000 u/mL (SDV)</li> <li>4,000 u/mL (SDV)</li> <li>10,000 u/mL (SDV)</li> <li>10,000 u/mL-2 mL vial (MDV)</li> <li>20,000 u/mL-1 mL vial (MDV)</li> </ul>	Single-dose Vial (SDV): Inject the entire cor (Circle: IV or SC) Once a Week 3 Times a Week Other Multi-dose Vial (MDV): Inject mL (Circle: IV or SC) Once a Week 3 Times a Week Other	(units)	Quantity: Refills:
Procrit/ Epogen Biosimilar Retacrit	<ul> <li>2,000 u/mL (SDV)</li> <li>3,000 u/mL (SDV)</li> <li>4,000 u/mL (SDV)</li> <li>10,000 u/mL (SDV)</li> <li>10,000 u/mL-2 mL vial (MDV)</li> <li>20,000 u/mL-1 mL vial (MDV)</li> </ul>	Single-dose Vial (SDV): Inject the entire cor (Circle: IV or SC) Once a Week 3 Times a Week Other Multi-dose Vial (MDV): Inject mL (Circle: IV or SC) Once a Week 3 Times a Week Other	(units)	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 / DAW / May Not Substitute <b>Prescriber's Signature:</b>	Do Not Substitute / No Substitution /Date:	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:
CA, MA, NC & PR: Interchange is mandated unless Preso	riber writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa provider	rs, 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty

## **Oncology Supportive Therapy Enrollment Form**

	Please Co	omplete Patient and Prescriber Information			
Patient Name:		Patient DOB:Patient Phone:			
Prescriber Nan	rescriber Name: Prescriber Phone:				
<b>5 PRESCRI</b>	PTION INFORMATION				
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS		
Granix	300 mcg Vial     480 mcg Vial     300 mcg Prefilled Syringe     480 mcg Prefilled Syringe	Administer mcg once a day fordays	Quantity: Refills:		
Leukine	250 mcg vial (lyophilized) 500 mcg/mL vial (liquid)	Administermcg once a day fordays (Circle: IV or SC) Other:	Quantity: Refills:		
🗌 Neulasta	6 mg Prefilled Syringe	Inject 6 mg SC day after chemotherapy, every days Inject 6 mg SC for 2 doses 1 week apart Other:	Quantity: Refills:		
Neulasta Biosimilars Fulphila Fylnetra Nyvepria Stimufend Udenyca Ziextenzo	6 mg Prefilled Syringe	Inject 6 mg SC day after chemotherapy, every days Other:	Quantity: Refills:		
☐ Neulasta OnPro Kit	6 mg Prefilled Syringe with on- body injector	Apply to skin the day of chemo to Inject 6 mg SC day after     chemotherapy, every days     Other:	Quantity: Refills:		
🗌 Neupogen	☐ 300 mcg Vial ☐ 480 mcg Vial ☐ 300 mcg Prefilled Syringe ☐ 480 mcg Prefilled Syringe	Administer mcg once a day fordays (Circle: IV or SC) Other:	Quantity: Refills:		
Neupogen Biosimilars Nivestym Releuko Zarxio	<ul> <li>300 mcg Vial (n/a for Zarxio)</li> <li>480 mcg Vial (n/a for Zarxio)</li> <li>300 mcg Prefilled Syringe</li> <li>480 mcg Prefilled Syringe</li> </ul>	Administer mcg once a day fordays (Circle: IV or SC) Other:	Quantity: Refills:		
Nplate	125 mcg (SDV)     250 mcg (SDV)     500 mcg (SDV)	Inject _ mcg subcutaneously as one-time dose Inject _mcg subcutaneously once weekly Other:	Quantity: Refills:		
Rolvedon	13.2 mg Prefilled Syringe d in <u>pati</u> ent support programs	Inject 13.2 mg SC day after chemotherapy, every days Other:	Quantity: Refills: rovided as needed for administration		

STAMP SIGNATURE NOT ALLOWED

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"Dispense As Written" / Brand Medically Necessary / D DAW / May Not Substitute	o Not Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescri	ber writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa provid	lers, 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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