# Oncology Supportive Therapy
# Enrollment Form

CVS specialty®

**Fax Referral To:** 1-877-232-5455
**Address:** 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

**Phone:** 1-800-896-1464

## 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)
*Note: Carrier charges may apply. 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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____**Relationship 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 ☐ Office ☐ Other: _____

**Diagnosis (ICD-10):**

☐ Code: _____ Description: _____
☐ Code: _____ Description: _____
☐ Code: _____ Description: _____

**Patient Clinical Information:**

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Aranesp | Single-dose Vials:<br>☐ 25 mcg ☐ 40 mcg<br>☐ 60 mcg ☐ 100 mcg<br>☐ 150 mcg ☐ 200 mcg<br>☐ 300 mcg ☐ 500 mcg<br>Single-dose Prefilled Syringes:<br>☐ 10 mcg ☐ 25 mcg<br>☐ 40 mcg ☐ 60 mcg<br>☐ 100 mcg ☐ 150 mcg<br>☐ 200 mcg ☐ 300 mcg<br>☐ 500 mcg | ☐ Inject the entire contents of vial/syringe once a week<br>(Circle: IV or SC)<br>☐ Inject the entire contents of vial/syringe every 3 weeks<br>(Circle: IV or SC)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Epogen<br>OR<br>☐ Procrit | ☐ 2,000 u/mL (SDV)<br>☐ 3,000 u/mL (SDV)<br>☐ 4,000 u/mL (SDV)<br>☐ 10,000 u/mL (SDV)<br>☐ 10,000 u/mL-2 mL vial (MDV)<br>☐ 20,000 u/mL-1 mL vial (MDV) | ☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial<br>(Circle: IV or SC)<br>☐ Once a Week ☐ 3 Times a Week ☐ Other: _____<br><br>☐ Multi-dose Vial (MDV): Inject _____ mL (_____units)<br>(Circle: IV or SC)<br>☐ Once a Week ☐ 3 Times a Week ☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| Procrit/<br>Epogen<br>Biosimilar<br>☐ Retacrit | ☐ 2,000 u/mL (SDV)<br>☐ 3,000 u/mL (SDV)<br>☐ 4,000 u/mL (SDV)<br>☐ 10,000 u/mL (SDV)<br>☐ 10,000 u/mL-2 mL vial (MDV)<br>☐ 20,000 u/mL-1 mL vial (MDV) | ☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial<br>(Circle: IV or SC)<br>☐ Once a Week ☐ 3 Times a Week ☐ Other: _____<br><br>☐ Multi-dose Vial (MDV): Inject _____ mL (_____units)<br>(Circle: IV or SC)<br>☐ Once a Week ☐ 3 Times a Week ☐ Other: _____ | Quantity: _____<br>Refills: _____ |

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## Enrollment Form

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Granix | ☐ 300 mcg Vial<br>☐ 480 mcg Vial<br>☐ 300 mcg Prefilled Syringe<br>☐ 480 mcg Prefilled Syringe | ☐ Administer _____ mcg once a day for _____days<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Leukine | ☐ 250 mcg vial (lyophilized)<br>☐ 500 mcg/mL vial (liquid) | ☐ Administer _____mcg once a day for _____days<br>(Circle: IV or SC)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Neulasta | 6 mg Prefilled Syringe | ☐ Inject 6 mg SC day after chemotherapy, every _____ days<br>☐ Inject 6 mg SC for 2 doses 1 week apart<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| Neulasta Biosimilars<br>☐ Fulphila<br>☐ Fylnetra<br>☐ Nyvepria<br>☐ Stimufend<br>☐ Udenyca<br>☐ Ziextenzo | 6 mg Prefilled Syringe | ☐ Inject 6 mg SC day after chemotherapy, every _____ days<br>☐ Other: _____ | Quantity: _____<br>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<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Neupogen | ☐ 300 mcg Vial<br>☐ 480 mcg Vial<br>☐ 300 mcg Prefilled Syringe<br>☐ 480 mcg Prefilled Syringe | ☐ Administer _____ mcg once a day for _____days<br>(Circle: IV or SC)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| Neupogen Biosimilars<br>☐ Nivestym<br>☐ Releuko<br>☐ Zarxio | ☐ 300 mcg Vial (n/a for Zarxio)<br>☐ 480 mcg Vial (n/a for Zarxio)<br>☐ 300 mcg Prefilled Syringe<br>☐ 480 mcg Prefilled Syringe | ☐ Administer _____ mcg once a day for _____days<br>(Circle: IV or SC)<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Nplate | ☐ 125 mcg (SDV)<br>☐ 250 mcg (SDV)<br>☐ 500 mcg (SDV) | ☐ Inject _ mcg subcutaneously as one-time dose<br>☐ Inject _mcg subcutaneously once weekly<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Rolvedon | 13.2 mg Prefilled Syringe | ☐ Inject 13.2 mg SC day after chemotherapy, every _____ days<br>☐ Other: _____ | Quantity: _____<br>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.