Pomalyst/Revlimid/Thalomid 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: _____ 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: _____ DOB: _____ Gender: ☐ Male ☐ Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

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 _____

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

Medications:

☐ Revlimid REMS Program Physician Auth #: _____ Date: _____

☐ Pomalyst REMS Program Physician Auth #: _____ Date: _____

☐ Thalomid REMS Program Physician Auth #: _____ Date: _____

Diagnosis:

☐ MDS D46.9

☐ MM C90.00

☐ MCL C83.10

Pregnancy Category:

☐ Adult Female – Reproductive Potential

☐ Female Child – Reproductive Potential

☐ Adult Female – NOT of Reproductive Potential

☐ Female Child – NOT of Reproductive Potential

☐ Adult Male

☐ Male Child

Medications:

☐ Pomalyst (pomalidomide) ☐ Revlimid (lenalidomide) ☐ Thalomid (thalidomide)

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 2	☐ Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 3	☐ Dexamethasone	Other: _____	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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.