

Breast Cancer Oncology Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

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/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

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):

☐ C50 Malignant neoplasm of breast ☐ Code: _____ Description: _____
☐ Code: _____ Description: _____ ☐ Code: _____ Description: _____

Patient Clinical Information: Allergies: _____ Weight: _____lb/kg Height: _____in/cm BSA: _____m²

5 PRESCRIPTION INFORMATION

Medications:

<input type="checkbox"/> Afinitor (everolimus)	<input type="checkbox"/> Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)	<input type="checkbox"/> Onxol (paclitaxel)
<input type="checkbox"/> Arimidex (anastrozole)	<input type="checkbox"/> Herzuma (trastuzumab-pkrb)	<input type="checkbox"/> Paclitaxel
<input type="checkbox"/> Aromasin (exemestane)	<input type="checkbox"/> Ibrance (palbociclib)	<input type="checkbox"/> Perjeta (pertuzumab)
<input type="checkbox"/> Capecitabine	<input type="checkbox"/> Ixempra (ixabepilone)	<input type="checkbox"/> Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)
<input type="checkbox"/> Cisplatin	<input type="checkbox"/> Kadcyra (ado-trastuzumab emtansine)	<input type="checkbox"/> Piqray (alpelisib)
<input type="checkbox"/> Enhertu (fam-trastuzumab deruxtecan-nxki)	<input type="checkbox"/> Kanjinti (trastuzumab-anns)	<input type="checkbox"/> Talzena (talazoparib)
<input type="checkbox"/> Fareston (toremifene citrate)	<input type="checkbox"/> Kisqali (ribociclib)	<input type="checkbox"/> Trazimera (trastuzumab-qyyp)
<input type="checkbox"/> Faslodex (fulvestrant)	<input type="checkbox"/> Kisqali Femara (ribociclib and letrozole)	<input type="checkbox"/> Tykerb (lapatinib)
<input type="checkbox"/> Femara (letrozole)	<input type="checkbox"/> Margenza (margetuximab-cmkb)	<input type="checkbox"/> Verzenio (abemaciclib)
<input type="checkbox"/> Fluorouracil	<input type="checkbox"/> Nerlynx (neratinib)	<input type="checkbox"/> Xeloda (capecitabine)
<input type="checkbox"/> Halaven (eribulin mesylate)	<input type="checkbox"/> Ogivri (trastuzumab-dkst)	<input type="checkbox"/> Zoladex (goserelin acetate implant)
<input type="checkbox"/> Herceptin (trastuzumab)	<input type="checkbox"/> Ontruzant (trastuzumab-dttb)	<input type="checkbox"/> Other _____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
RX 2	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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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