Breast Cancer Oncology Enrollment Form

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

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 (primary # provided below) ☐ Text (cell # provided below) ☐ Email (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):

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

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

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.CVSspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information: Allergies: _____ Weight: ____lb/kg Height: ____in/cm BSA: _____ m^2

5 PRESCRIPTION INFORMATION

Medications:

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

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

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.
Patient Signature:_____

☐ 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) DISPENSE AS WRITTEN (Date)

X_____ 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 below, 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 and/or one of its affiliates. ©2020 CVS Specialty and/or one of its affiliates. 75-53242A 111820