Non-Small Cell Lung Cancer Medications Enrollment Form
Medications A-K

(Avastin, Alecensa, Cyramza, Erlotinib, Gavreto, Imfinzi, Iressa, Keytruda)

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.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 (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 ___________________________

☐ Code: _______ Description _________________________ ☐ Code: _____ Description ___________________________

Patient Clinical Information:

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

Biomarker(s): ☐ ALK+ ☐ BRAF V600E ☐ EGFR + ☐ EGFR/T790M+ ☐ KRAS G12C+ ☐ METex14+ ☐ NTRK1/2/3+ ☐ RET+ ☐ ROS1+ ☐ PD-L1 <1% ☐ PD-L1 ≥1%-49% ☐ PD-L1 ≥ 50% ☐ No actionable molecular marker

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
☐ Avastin	☐ 100 mg/4 mL ☐ 400 mg/16 mL	☐ 15 mg/kg IV every three weeks ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Alecensa	150 mg	☐ 4 capsules PO twice daily #240 ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Cyramza	☐ 100 mg/10 mL ☐ 500 mg/50 mL	☐ 10 mg/kg IV once every two weeks ☐ 10 mg/kg IV once every three weeks ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Erlotinib	☐ 25 mg ☐ 100mg ☐ 150 mg	☐ 1 tablet PO once daily #30 ☐ 3 tablets PO once daily #90 ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Gavreto	100 mg	☐ 4 capsules PO once daily #120 ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Imfinzi	☐ 120 mg/2.4 mL ☐ 500 mg/10 mL	☐ 10 mg/kg IV every two weeks ☐ 20 mg/kg IV every three weeks ☐ 1,500 mg IV every four weeks ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Iressa	250 mg	☐ 1 tablet PO once daily #30 ☐ Other: ______________________	Quantity:_______ Refills:_______
☐ Keytruda	100 mg/4 mL	☐ 200 mg IV every three weeks ☐ 400 mg IV every six weeks ☐ 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 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.

©2021 CVS Pharmacy, Inc. or one of its affiliates. 75-55092A 061721

Non-Small Cell Lung Cancer Medications Enrollment Form
Medications L-Z

(Libtayo, Lorbrena, Lumakras, Mekinist, Opdivo, Retevmo, Rozlytrek, Tabrecta, Tafinlar, Tagrisso, Tecentriq, Vizimpro, Xalkori, Yervoy, Zykadia)

Please Complete Patient and Prescriber Information

Patient Name: ____________________ Patient DOB: ____________________

Prescriber Name: ____________________ Prescriber Phone: ____________________

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
☐ Libtayo	350 mg/7 mL	☐ 350 mg IV every three weeks ☐ Other: ________	Quantity:______ Refills:______
☐ Lorbrena	☐ 25 mg ☐ 100 mg	☐ 1 tablet PO once daily #30 ☐ Other: ________	Quantity:______ Refills:______
☐ Lumakras	120 mg	☐ 8 tablets PO once daily #240 ☐ Other: ________	Quantity:______ Refills:______
☐ Mekinist	☐ 0.5 mg ☐ 2 mg	☐ 1 tablet PO once daily #30 ☐ Other: ________	Quantity:______ Refills:______
☐ Opdivo	☐ 40 mg/4 mL ☐ 100 mg/10 mL ☐ 240 mg/24 mL	☐ 240 mg IV every two weeks ☐ 480 mg IV every four weeks ☐ 360 mg IV every three weeks ☐ 3 mg/kg IV every two weeks ☐ Other: ________	Quantity:______ Refills:______
☐ Retevmo	☐ 40 mg ☐ 80 mg	☐ 2 capsules PO twice daily #120 ☐ 3 capsules PO twice daily #180 ☐ Other: ________	Quantity:______ Refills:______
☐ Rozlytrek	☐ 100 mg ☐ 200 mg	☐ 3 capsules PO once daily #90 ☐ Other: ________	Quantity:______ Refills:______
☐ Tabrecta	☐ 150 mg ☐ 200 mg	☐ 2 tablets PO twice daily #112 ☐ Other: ________	Quantity:______ Refills:______
☐ Tafinlar	☐ 50 mg ☐ 75 mg	☐ 2 capsules PO twice daily #120 ☐ Other: ________	Quantity:______ Refills:______
☐ Tagrisso	☐ 40 mg ☐ 80 mg	☐ 1 tablet PO once daily #30 ☐ Other: ________	Quantity:______ Refills:______
☐ Tecentriq	☐ 840 mg/14 mL ☐ 1,200 mg/20 mL	☐ 1,200 mg IV every two weeks ☐ Other: ________	Quantity:______ Refills:______
☐ Vitrakvi	☐ 25 mg ☐ 100 mg	☐ 1 capsule PO twice daily #60 ☐ Other: ________	Quantity:______ Refills:______
☐ Vizimpro	☐ 15 mg ☐ 45 mg ☐ 30 mg	☐ 1 tablet PO once daily #30 ☐ Other: ________	Quantity:______ Refills:______
☐ Xalkori	☐ 200 mg ☐ 250 mg	☐ 1 capsule PO twice daily #60 ☐ Other: ________	Quantity:______ Refills:______
☐ Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 1 mg/kg IV every six weeks ☐ Other: ________	Quantity:______ Refills:______
☐ Zykadia	150 mg	☐ 3 tablets PO once daily #90 ☐ Other: ________	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)

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.

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. ©2021 CVS Specialty and/or one of its affiliates. 75-55092A 061721