

Oncology Oral Medications 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)
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)*

Is the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No
Policy Holder's Name: _____ Policy Holder's DOB: _____
Relationship to Patient: _____ Medical Insurance: _____ Telephone: _____ Policy ID: _____
Group #: _____ Prescription Insurance: _____ Prescription Plan Telephone: _____
RX BIN #: _____ RX PCN #: _____
 Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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: _____ m²

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 – NOT of Reproductive Potential
 Female Child – Reproductive Potential Adult Male
 Adult Female – NOT of Reproductive Potential Male Child

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Medications A-Z

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone Number: _____
 Prescriber Name: _____ Prescriber Phone: _____

Medications

- | | | |
|---|--|--|
| <input type="checkbox"/> Afinitor (everolimus)
<input type="checkbox"/> Afinitor Disperz (everolimus)
<input type="checkbox"/> Alecensa (alectinib)
<input type="checkbox"/> Augtyro (repotrectinib)
<input type="checkbox"/> Balversa (erdafitinib)
<input type="checkbox"/> Bosulif (bosutinib)
<input type="checkbox"/> Braftovi (encorafenib)
<input type="checkbox"/> Cabometyx (cabozantinib)
<input type="checkbox"/> Cometriq (cabozantinib)
<input type="checkbox"/> Copiktra (duvelisib)
<input type="checkbox"/> Cotellic (cobimetinib)
<input type="checkbox"/> Cytosan Capsules (cyclophosphamide)
<input type="checkbox"/> Daurismo (glasdegib)
<input type="checkbox"/> Erivedge (vismodegib)
<input type="checkbox"/> Erleada (apalutamide)
<input type="checkbox"/> Gleevec (imatinib mesylate)
<input type="checkbox"/> Gleostine (lomustine)
<input type="checkbox"/> Hycamtin Capsules (topotecan)
<input type="checkbox"/> Ibrance (palbociclib)
<input type="checkbox"/> Idhifa (enasidenib)
<input type="checkbox"/> Imkeldi (imatinib)
<input type="checkbox"/> Inlyta (axitinib)
<input type="checkbox"/> Inqovi (decitabine and cedazuridine)
<input type="checkbox"/> Inrebic (fedratinib)
<input type="checkbox"/> Iressa (gefitinib)
<input type="checkbox"/> Itovebi (inavolisib)
<input type="checkbox"/> Jakafi (ruxolitinib) | <input type="checkbox"/> Jayprica (pirtobrutinib)
<input type="checkbox"/> Kisqali (ribociclib)
<input type="checkbox"/> Lenvima (Lenvatinib)
<input type="checkbox"/> Lonsurf (trifluridine & tipiracil)
<input type="checkbox"/> Lorbrena (lorlatinib)
<input type="checkbox"/> Lumakras (sotorasib)
<input type="checkbox"/> Lynparza (olaparib)
<input type="checkbox"/> Mekinist (trametinib)
<input type="checkbox"/> Mektovi (binimetinib)
<input type="checkbox"/> Nerlynx (neratinib)
<input type="checkbox"/> Nexavar (sorafenib)
<input type="checkbox"/> Ninlaro (ixazomib)
<input type="checkbox"/> Nubeqa (darolutamide)
<input type="checkbox"/> Odomzo (sonidegib)
<input type="checkbox"/> Onureg (azacitidine)
<input type="checkbox"/> Piqray (alpelisib)
<input type="checkbox"/> Pomalyst (pomalidomide)
<input type="checkbox"/> Purixan (mercaptopurine)
<input type="checkbox"/> Retevmo (selpercatinib)
<input type="checkbox"/> Revlimid (lenalidomide)
<input type="checkbox"/> Rozlytrek (entrectinib)
<input type="checkbox"/> Rubraca (rucaparib)
<input type="checkbox"/> Rydapt (midostaurin)
<input type="checkbox"/> Sprycel (dasatinib)
<input type="checkbox"/> Stivarga (regorafenib)
<input type="checkbox"/> Sutent (sunitinib malate)
<input type="checkbox"/> Tabrecta (capmatinib) | <input type="checkbox"/> Tafenlar (dabrafenib)
<input type="checkbox"/> Tagrisso (osimertinib)
<input type="checkbox"/> Talzena (talazoparib)
<input type="checkbox"/> Tarceva (erlotinib)
<input type="checkbox"/> Targretin Capsules (bexarotene)
<input type="checkbox"/> Tassigna (nilotinib)
<input type="checkbox"/> Temodar Capsules (temozolomide)
<input type="checkbox"/> Thalomid (thalidomide)
<input type="checkbox"/> Tykerb (lapatinib)
<input type="checkbox"/> Vepesid Capsules (etoposide)
<input type="checkbox"/> Verzenio (abemaciclib)
<input type="checkbox"/> Vitkrvi (larotrectinib)
<input type="checkbox"/> Vizimpro (dacomitinib)
<input type="checkbox"/> Votrient (pazopanib)
<input type="checkbox"/> Xalkori (crizotinib)
<input type="checkbox"/> Xeloda (capecitabine)
<input type="checkbox"/> Xospata (gilteritinib)
<input type="checkbox"/> Xtandi (enzalutamide)
<input type="checkbox"/> Yonsa (abiraterone acetate)
<input type="checkbox"/> Zejula (niraparib)
<input type="checkbox"/> Zelboraf (vemurafenib)
<input type="checkbox"/> Zolanza (vorinostat)
<input type="checkbox"/> Zydelig (idelalisib)
<input type="checkbox"/> Zykadia (ceritinib)
<input type="checkbox"/> Zytiga (abiraterone)
<input type="checkbox"/> Other: _____ |
|---|--|--|

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.

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.

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone Number: _____

Prescriber Name: _____ Prescriber Phone: _____

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: _____
RX 3	<input type="checkbox"/> Anastrozole <input type="checkbox"/> Letrozole <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Prednisone <input type="checkbox"/> Exemestane <input type="checkbox"/> Zoladex <input type="checkbox"/> Fulvestrant	<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

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