

Oncology Supportive Therapy 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: 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: _____ 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)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

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

Patient Clinical Information:

Allergies: _____ Height: _____ in/cm Weight: _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Aranesp	Single-dose Vials: <input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 150 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 500 mcg Single-dose Prefilled Syringes: <input type="checkbox"/> 10 mcg <input type="checkbox"/> 25 mcg <input type="checkbox"/> 40 mcg <input type="checkbox"/> 60 mcg <input type="checkbox"/> 100 mcg <input type="checkbox"/> 150 mcg <input type="checkbox"/> 200 mcg <input type="checkbox"/> 300 mcg <input type="checkbox"/> 500 mcg	<input type="checkbox"/> Inject the entire contents of vial/syringe once a week (Circle: IV or SC) <input type="checkbox"/> Inject the entire contents of vial/syringe every 3 weeks (Circle: IV or SC) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Epogen OR <input type="checkbox"/> Procrit	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial (Circle: IV or SC) <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) (Circle: IV or SC) <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
Procrit/ Epogen Biosimilar <input type="checkbox"/> Retacrit	<input type="checkbox"/> 2,000 u/mL (SDV) <input type="checkbox"/> 3,000 u/mL (SDV) <input type="checkbox"/> 4,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL (SDV) <input type="checkbox"/> 10,000 u/mL-2 mL vial (MDV) <input type="checkbox"/> 20,000 u/mL-1 mL vial (MDV)	<input type="checkbox"/> Single-dose Vial (SDV): Inject the entire contents of 1 vial (Circle: IV or SC) <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multi-dose Vial (MDV): Inject _____ mL (_____ units) (Circle: IV or SC) <input type="checkbox"/> Once a Week <input type="checkbox"/> 3 Times a Week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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Please Complete Patient and Prescriber Information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Granix	<input type="checkbox"/> 300 mcg Vial <input type="checkbox"/> 480 mcg Vial <input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer ____ mcg once a day for ____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Leukine	<input type="checkbox"/> 250 mcg vial (lyophilized) <input type="checkbox"/> 500 mcg/mL vial (liquid)	<input type="checkbox"/> Administer ____ mcg once a day for ____ days (Circle: IV or SC) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neulasta	6 mg Prefilled Syringe	<input type="checkbox"/> Inject 6 mg SC day after chemotherapy, every ____ days <input type="checkbox"/> Inject 6 mg SC for 2 doses 1 week apart <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
Neulasta Biosimilars <input type="checkbox"/> Fulphila <input type="checkbox"/> Fylmetra <input type="checkbox"/> Nyvepria <input type="checkbox"/> Stimufend <input type="checkbox"/> Udenyca <input type="checkbox"/> Ziextenzo	6 mg Prefilled Syringe	<input type="checkbox"/> Inject 6 mg SC day after chemotherapy, every ____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neulasta OnPro Kit	6 mg Prefilled Syringe with on-body injector	<input type="checkbox"/> Apply to skin the day of chemo to Inject 6 mg SC day after chemotherapy, every ____ days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Neupogen	<input type="checkbox"/> 300 mcg Vial <input type="checkbox"/> 480 mcg Vial <input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer ____ mcg once a day for ____ days (Circle: IV or SC) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
Neupogen Biosimilars <input type="checkbox"/> Nivestym <input type="checkbox"/> Releuko <input type="checkbox"/> Zarxio	<input type="checkbox"/> 300 mcg Vial (n/a for Zarxio) <input type="checkbox"/> 480 mcg Vial (n/a for Zarxio) <input type="checkbox"/> 300 mcg Prefilled Syringe <input type="checkbox"/> 480 mcg Prefilled Syringe	<input type="checkbox"/> Administer ____ mcg once a day for ____ days (Circle: IV or SC) <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Nplate	<input type="checkbox"/> 125 mcg (SDV) <input type="checkbox"/> 250 mcg (SDV) <input type="checkbox"/> 500 mcg (SDV)	<input type="checkbox"/> Inject ____ mcg subcutaneously as one-time dose <input type="checkbox"/> Inject ____ mcg subcutaneously once weekly <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rolvedon	13.2 mg Prefilled Syringe	<input type="checkbox"/> Inject 13.2 mg SC day after chemotherapy, every ____ days <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)

"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.

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