

Pomalyst/Revlimid/Thalomid 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 927

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: _____

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

Medications:

Pomalyst (pomalidomide) Revlimid (lenalidomide) Thalomid (thalidomide)

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 2	<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 3	<input type="checkbox"/> Dexamethasone	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.

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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