# Non-Small Cell Lung Cancer Medications Enrollment Form
# Medications A-K
**(Avastin, Alecensa, Cyramza, Erlotinib, Gavreto, Imfinzi, Iressa, Keytruda)**

CVS specialty®

**Fax Referral To:** 1-800-323-2445
**Email Referral To:** Customer.ServiceFax@CVSHealth.com
**Phone:** 1-800-237-2767

## 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<br>☐ 400 mg/16 mL | ☐ 15 mg/kg IV every three weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Alecensa | 150 mg | ☐ 4 capsules PO twice daily #240<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Cyramza | ☐ 100 mg/10 mL<br>☐ 500 mg/50 mL | ☐ 10 mg/kg IV once every two weeks<br>☐ 10 mg/kg IV once every three weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Erlotinib | ☐ 25 mg<br>☐ 100mg<br>☐ 150 mg | ☐ 1 tablet PO once daily #30 ☐ 3 tablets PO once daily #90<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Gavreto | 100 mg | ☐ 4 capsules PO once daily #120<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Imfinzi | ☐ 120 mg/2.4 mL<br>☐ 500 mg/10 mL | ☐ 10 mg/kg IV every two weeks ☐ 20 mg/kg IV every three weeks<br>☐ 1,500 mg IV every four weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Iressa | 250 mg | ☐ 1 tablet PO once daily #30<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Keytruda | 100 mg/4 mL | ☐ 200 mg IV every three weeks ☐ 400 mg IV every six weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |

☐ 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.

# 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<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Lorbrena | ☐ 25 mg<br>☐ 100 mg | ☐ 1 tablet PO once daily #30<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Lumakras | 120 mg | ☐ 8 tablets PO once daily #240<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Mekinist | ☐ 0.5 mg<br>☐ 2 mg | ☐ 1 tablet PO once daily #30<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Opdivo | ☐ 40 mg/4 mL<br>☐ 100 mg/10 mL<br>☐ 240 mg/24 mL | ☐ 240 mg IV every two weeks ☐ 480 mg IV every four weeks<br>☐ 360 mg IV every three weeks ☐ 3 mg/kg IV every two weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Retevmo | ☐ 40 mg<br>☐ 80 mg | ☐ 2 capsules PO twice daily #120<br>☐ 3 capsules PO twice daily #180<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Rozlytrek | ☐ 100 mg<br>☐ 200 mg | ☐ 3 capsules PO once daily #90<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Tabrecta | ☐ 150 mg<br>☐ 200 mg | ☐ 2 tablets PO twice daily #112<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Tafinlar | ☐ 50 mg<br>☐ 75 mg | ☐ 2 capsules PO twice daily #120<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Tagrisso | ☐ 40 mg<br>☐ 80 mg | ☐ 1 tablet PO once daily #30<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Tecentriq | ☐ 840 mg/14 mL<br>☐ 1,200 mg/20 mL | ☐ 1,200 mg IV every two weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Vitrakvi | ☐ 25 mg<br>☐ 100 mg | ☐ 1 capsule PO twice daily #60<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Vizimpro | ☐ 15 mg ☐ 45 mg<br>☐ 30 mg | ☐ 1 tablet PO once daily #30<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Xalkori | ☐ 200 mg<br>☐ 250 mg | ☐ 1 capsule PO twice daily #60<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Yervoy | ☐ 50 mg/10 mL<br>☐ 200 mg/40 mL | ☐ 1 mg/kg IV every six weeks<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| ☐ Zykadia | 150 mg | ☐ 3 tablets PO once daily #90<br>☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| RX 1 | ☐ Other: _____ | ☐ Other: _____ | Quantity:_____<br>Refills:_____ |
| RX 2 | ☐ Other: _____ | ☐ Other: _____ | Quantity:_____<br>Refills:_____ |

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PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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