

# Oncology Dermatology Medication Enrollment Form

## Medications A-O

(Cotellic, Erivedge, Keytruda, Mekinist, Odomzo, Opdivo)



Fax Referral To: 1-800-323-2445

Email Referral To: customerservicefax@caremark.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 (primary # provided below)  Text (cell # provided below)  Email (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 \_\_\_\_\_

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.CVSppecialty.com/wps/portal/specialty/healthcare-professionals/about-us)

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**Patient Clinical Information:** Allergies: \_\_\_\_\_ Weight: \_\_\_\_lb/kg Height: \_\_\_\_in/cm

#### 5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cotellic	20 mg	<input type="checkbox"/> 3 tablets PO once daily days 1-21, off 7 days. Recycle every 28 days. #63 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Erivedge	150 mg	<input type="checkbox"/> 1 capsule PO once daily #28 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Keytruda	100 mg/4 mL	<input type="checkbox"/> 200 mg IV every 3 weeks <input type="checkbox"/> 400 mg IV every 6 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Mekinist	<input type="checkbox"/> 2 mg <input type="checkbox"/> 0.5 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Odomzo	200 mg	<input type="checkbox"/> 1 capsule PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Opdivo	<input type="checkbox"/> 40 mg/4 mL <input type="checkbox"/> 100 mg/10 mL <input type="checkbox"/> 240 mg/24 mL	<input type="checkbox"/> 240 mg IV every two weeks <input type="checkbox"/> 480 mg IV every four weeks <input type="checkbox"/> 1 mg/kg IV every 3 weeks x 4 doses <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 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 below, 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.

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**Medications P-Z**  
**(Poteligeo, Tafinlar, Tecentriq, Yervoy, Zelboraf, Zolinza)**  
**Oncology Dermatology Medication Enrollment Form**

**Please Complete Patient and Prescriber information**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

**5 PRESCRIPTION INFORMATION**

DRUG NAME	STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Poteligeo	20 mg/5 mL	<input type="checkbox"/> 1 mg/kg IV Days 1, 8, 15, 22 x 1 cycle <input type="checkbox"/> 1 mg/kg IV every 2 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tafinlar	<input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/> 2 capsules PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tecentriq	840 mg/14 mL	<input type="checkbox"/> 840 mg IV every 2 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yervoy	<input type="checkbox"/> 50 mg/10 mL <input type="checkbox"/> 200 mg/40 mL	<input type="checkbox"/> 3 mg/kg IV every 3 weeks x 4 doses <input type="checkbox"/> 10 mg/kg IV every 3 weeks x 4 doses <input type="checkbox"/> 10 mg/kg IV every 12 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zelboraf	240 mg	<input type="checkbox"/> 4 tablets PO twice daily #240 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zolinza	100 mg	<input type="checkbox"/> 4 capsules PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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"/> Ondansetron <input type="checkbox"/> Promethazine	<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 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 below, 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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