Oncology Dermatology Medication Enrollment Form

Medications A-O

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

CVS specialty®

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.CVSspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information: Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

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

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 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.

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
☐ Poteligeo	20 mg/5 mL	☐ 1 mg/kg IV Days 1, 8, 15, 22 x 1 cycle ☐ 1 mg/kg IV every 2 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tafinlar	☐ 50 mg ☐ 75 mg	☐ 2 capsules PO twice daily #120 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tecentriq	840 mg/14 mL	☐ 840 mg IV every 2 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 3 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 12 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Zelboraf	240 mg	☐ 4 tablets PO twice daily #240 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Zolinza	100 mg	☐ 4 capsules PO once daily #120 ☐ Other: _____	Quantity:_____ Refills:_____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
Rx 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
Rx 2	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
Rx 3	☐ Ondansetron ☐ Promethazine	☐ 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)

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 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.