

Oncology Injectable and Infused Medication Enrollment Form



Fax Referral To: 888-435-1256

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 855-539-4712

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)
Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. 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: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to Patient: _____

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)

Is the Patient Insured? Yes No Is the Patient enrolled or eligible for Medicare/Medicaid? Yes No
Policy Holder's Name: _____ Policy Holder's DOB: _____
Relationship to Patient: _____ Medical Insurance: _____ Telephone: _____ Policy ID: _____
Group #: _____ Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____
Group #: _____ RX BIN #: _____ RX PCN #: _____
 Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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

Oncology Injectable and Infused Medication Enrollment Form

A-K

Please complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Medications:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abraxane
(nab-paclitaxel) | <input type="checkbox"/> Camptosar
(irinotecan) | <input type="checkbox"/> Elitek
(rasburicase) | <input type="checkbox"/> Imfinzi
(durvalumab) |
| <input type="checkbox"/> Adcetris
(brentuximab vedotin) | <input type="checkbox"/> Carboplatin | <input type="checkbox"/> Empliciti (elotuzumab) | <input type="checkbox"/> Imjudo
(tremelimumab-actl) |
| <input type="checkbox"/> Alimta
(pemetrexed) | <input type="checkbox"/> Cisplatin | <input type="checkbox"/> Enhertu
(fam-trastuzumab
deruxtecan-nxki) | <input type="checkbox"/> Irinotecan |
| <input type="checkbox"/> Almysys
(bevacizumab-maly) | <input type="checkbox"/> Cladribine | <input type="checkbox"/> Erbitux
(cetuximab) | <input type="checkbox"/> Istodax
(romidepsin) |
| <input type="checkbox"/> Arranon
(nelarabine) | <input type="checkbox"/> Columvi (glofitamab-gxbm) | <input type="checkbox"/> Erwinaze
(asparaginase Erwinia
chrysanthemii) | <input type="checkbox"/> Ixempra
(ixabepilone) |
| <input type="checkbox"/> Asparlas
(calaspargase pegol-mknl) | <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> Gazyva
(obinutuzumab) | <input type="checkbox"/> Jemperli
(dostarlimab-gxly) |
| <input type="checkbox"/> Avastin
(bevacizumab) | <input type="checkbox"/> Cyramza
(ramucirumab) | <input type="checkbox"/> Herceptin
(trastuzumab) | <input type="checkbox"/> Jevtana
(cabazitaxel) |
| <input type="checkbox"/> Beleodaq
(belinostat) | <input type="checkbox"/> Cytarabine | <input type="checkbox"/> Herceptin Hylecta
(trastuzumab and
trastuzumab and
hyaluronidase-oysk) | <input type="checkbox"/> Kadcylla
(ado-trastuzumab emtansine) |
| <input type="checkbox"/> Belrapzo
(bendamustine) | <input type="checkbox"/> Dacarbazine | <input type="checkbox"/> Ifosfamide | <input type="checkbox"/> Keytruda
(pembrolizumab) |
| <input type="checkbox"/> Bendeka
(bendamustine) | <input type="checkbox"/> Dactinomycin
(daratumumab) | | <input type="checkbox"/> Kanjinti
(trastuzumab-anns) |
| <input type="checkbox"/> Besponsa
(inotuzumab ozogamicin) | <input type="checkbox"/> Darzalex Faspro
(daratumumab and
hyaluronidase-fihj) | | <input type="checkbox"/> Kyprolis
(carfilzomib) |
| <input type="checkbox"/> BiCNU
(carmustine) | <input type="checkbox"/> Darzalex
(daratumumab) | | |
| <input type="checkbox"/> Bleomycin | <input type="checkbox"/> Datroway (datopotamab
deruxtecan-dlnk) | | |
| | <input type="checkbox"/> Daunorubicin | | |
| | <input type="checkbox"/> Decitabine | | |
| | <input type="checkbox"/> Dexrazoxane | | |
| | <input type="checkbox"/> Docetaxel | | |
| | <input type="checkbox"/> Doxorubicin | | |
| | <input type="checkbox"/> Doxorubicin liposomal | | |

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"/> Other: _____	<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)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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.

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.

Oncology Injectable and Infused Medication Enrollment Form

L-Z

Please complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Medications:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Leucovorin | (enfortumab vedotin-ejfv) | <input type="checkbox"/> Sylvant | <input type="checkbox"/> Velcade |
| <input type="checkbox"/> Leveleucovorin | <input type="checkbox"/> Pamidronate | (siltuximab) | (bortezomib) |
| <input type="checkbox"/> Lunsumio | <input type="checkbox"/> Perjeta | <input type="checkbox"/> Tecentriq (atezolizumab) | <input type="checkbox"/> Vidaza |
| (mosunetuzumab-axgb) | (pertuzumab) | <input type="checkbox"/> Tecentriq Hybreza | (azacitidine) |
| <input type="checkbox"/> Margenza | <input type="checkbox"/> Phesgo | (atezolizumab and | <input type="checkbox"/> Vinblastine |
| (margetuximab-cmkb) | (pertuzumab, trastuzumab, and | hyaluronidase-tqjs) | <input type="checkbox"/> Vincristine |
| <input type="checkbox"/> Melphalan | hyaluronidase-zzxf) | <input type="checkbox"/> Temsirolimus | <input type="checkbox"/> Vinorelbine |
| <input type="checkbox"/> Mesna | <input type="checkbox"/> Polivy | <input type="checkbox"/> Thyrogen | <input type="checkbox"/> Vyxeos |
| <input type="checkbox"/> Mitomycin | (polatuzumab vedotin-piiq) | (thyrotropin alfa) | (daunorubicin/cytarabine |
| <input type="checkbox"/> Mvasi | <input type="checkbox"/> Poteligeo (mogamulizumab- | <input type="checkbox"/> Tice BCG | (liposomal) |
| (bevacizumab-awwb) | kpkc) | <input type="checkbox"/> Tivdak | <input type="checkbox"/> Xgeva (denosumab) |
| <input type="checkbox"/> Mylotarg | <input type="checkbox"/> Proleukin | (tisotumab vedotin-tftv) | <input type="checkbox"/> Yervoy (ipilimumab) |
| (gemtuzumab ozogamicin) | (aldesleukin, IL-2) | <input type="checkbox"/> Topotecan | <input type="checkbox"/> Yondelis |
| <input type="checkbox"/> Niktimvo (axatilimab-csfr) | <input type="checkbox"/> Riabni | <input type="checkbox"/> Trazimera | (trabectedin) |
| <input type="checkbox"/> Onivyde | (rituximab-arrx) | <input type="checkbox"/> Treanda | <input type="checkbox"/> Zaltrap |
| (irinotecan liposomal) | <input type="checkbox"/> Rituxan (rituximab) | <input type="checkbox"/> Trisenox (arsenic trioxide) | (ziv-aflibercept) |
| <input type="checkbox"/> Ontruzant | <input type="checkbox"/> Rituxan Hycela | <input type="checkbox"/> Truxima | <input type="checkbox"/> Zepzelca (lurbinedectin) |
| (trastuzumab-dttb) | (rituximab | (rituximab-abbs) | <input type="checkbox"/> Ziihera (zanidatamab-hrii) |
| <input type="checkbox"/> Opdivo (nivolumab) | and hyaluronidase human) | <input type="checkbox"/> Valrubicin | <input type="checkbox"/> Zirabev |
| <input type="checkbox"/> Opdivo Qvantiq | <input type="checkbox"/> Ruxience | <input type="checkbox"/> Unloxcyt | (bevacizumab-bvzr) |
| (nivolumab and hyaluronidase- | (rituximab-pvvr) | <input type="checkbox"/> Vectibix | <input type="checkbox"/> Zoledronic Acid |
| nvhy) | <input type="checkbox"/> Rybrevant | (panitumumab) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Opdualag | (amivantamab-vmjw) | <input type="checkbox"/> Vegzelma | |
| (nivolumab and | <input type="checkbox"/> Rylaze | (bevacizumab-adcd) | |
| relatimab-rmbw) | (asparaginase erwinia | | |
| <input type="checkbox"/> Oxaliplatin | chrysanthemi-rywn) | | |
| <input type="checkbox"/> Paclitaxel | <input type="checkbox"/> Sarclisa (isatuximab-irfc) | | |
| <input type="checkbox"/> Padcev | | | |

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"/> Other: _____	<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.

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.