

Pomalyst/Revlimid/Thalomid Enrollment Form



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: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: 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: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

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

Prescriber Name: _____ Prescriber Phone: _____

State License #: _____ NPI #: _____ DEA #: _____

Group or Hospital: _____ Address: _____

City, State, ZIP Code: _____ 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

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: _____ |

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.

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