

# Oncology Oral Medications Hematologic Malignancies Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161  
 Phone: 1-888-280-1190 OR 787-759-4162  
 Email Referral To: customerservicefax@caremark.com  
 Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 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: \_\_\_\_\_  
 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: \_\_\_\_\_

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

<https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us>

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm BSA: \_\_\_\_\_ m<sup>2</sup>

### 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  Adult Female – NOT of Reproductive Potential  Adult Male  
 Female Child – Reproductive Potential  Female Child – NOT of Reproductive Potential  Male Child

#### Medications:

Bosulif® (bosutinib)  Lumoxiti™ (moxetumomab)  Rydapt® (midostaurin)  Zydelig® (idelalisib)  
 Farydak® (panobinostat)  Ninlaro® (ixazomib)  Sprycel® (dasatinib)  Other: \_\_\_\_\_  
 Gleevec® (imatinib mesylate)  Pomalyst® (pomalidomide)  Targretin® Capsules (bexarotene)  
 Idhifa® (enasidenib)  Poteligeo® (moxetumomab)  Tassigna® (nilotinib)  
 Inrebic® (fedratinib)  Purixan® (mercaptopurine)  Thalomid® (thalidomide)  
 Jakafi® (ruxolitinib)  Revlimid® (lenalidomide)  Zolinza® (vorinostat)

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"/> Dexamethasone	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: \_\_\_\_\_

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.

©2018 CVS Specialty and/or one of its affiliates. 75-35450E 092719