## **Oncology Dermatology Medication Enrollment Form**

## **Medications A-O**

(Braftovi, Cotellic, Erivedge, Keytruda, Mekinist, Mektovi, Odomzo, Opdivo, Opdualag)



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 Phone: 1-808-254-2727

NCPDP: 1203417 Six Simple Steps to Submitting a Referral **PATIENT INFORMATION** (Complete or include demographic sheet) PATIENT INFORMATION (Complete or include demographic sheet) Patient Name: Gender: Male Female City, State, ZIP Code: Address: Preferred Contact Methods: 0 Phone (to primary # provided below) 0 Text (to cell # provided below) 0 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: Last Four of SSN: Primary Language: \_\_\_\_ Parent/Caregiver/Legal Guardian Name (Last, First): Relationship Patient: 2 PRESCRIBER INFORMATION Prescriber's Name: \_\_\_ \_\_\_\_\_ State License #: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_ Group or Hospital: \_\_\_ Address: \_\_\_\_ \_\_ City, State, ZIP Code: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_ Phone: \_\_\_\_ Contact's Phone: \_\_\_\_ 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 Weight: lb/kg Height: in/cm Patient Clinical Information: Allergies: 5 PRESCRIPTION INFORMATION **DRUG NAME** STRENGTH SIG/DIRECTIONS **QUANTITY/REFILLS** 450 mg PO once daily in combination with Mektovi 45 mg PO twice daily \_\_\_ 50 mg Quantity:\_ ☐ Braftovi 300 mg PO once daily in combination with Erbitux \_\_\_\_ 75 mg Refills:\_\_\_ Other: Ouantity: 3 tablets PO once daily days 1-21, off 7 days. Recycle every 28 days. ☐ Cotellic 20 mg Refills: 1 capsule PO once daily Quantity: ☐ Erivedge 150 mg Refills: Quantity:\_\_\_ 200 mg IV every 3 weeks 400 mg IV every 6 weeks 100 mg/4 mL Refills: Other: 1 tablet PO once daily ☐ 2 mg Quantity:\_ ☐ 0.5 mg Refills: Quantity: 45 mg PO twice daily in combination with Braftovi 450 mg PO once daily ☐ Mektovi 15 mg Refills: 1 capsule PO once daily Quantity: Odomzo 200 mg Other: Refills: 240 mg IV every two weeks 480 mg IV every four weeks Quantity: ☐ 40 mg/4 mL ☐ 3mg/kg IV every two weeks ☐ 6mg/kg IV every four weeks Refills: Opdivo ☐ 100 mg/10 mL 1 mg/kg IV every 3 weeks x 4 doses 240 mg/24 mL Other: Opdualag Quantity:\_\_ (nivolumab and 240 mg-80 mg/20 mL 480 mg nivolumab and 160 mg relatlimab IV every 4 weeks relatimab-rmbw) Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: \_ Prescriber's Signature: \_

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.

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_

\_ ATTN: New York and Iowa providers, please submit electronic prescription

## **Oncology Dermatology Medication Enrollment Form**

## **Medications P-Z**

(Poteligeo, Tafinlar, Tecentriq, Yervoy, Zelboraf, Zolinza)

	Ple	ase Complete Patient a	and Prescriber Information	
Patient Name:		Patient DOB: _	nt DOB:Patient Phone Number	
Prescriber Na	ame:		Prescriber Phone:	
5 PRESCRIP	TION INFORMATIO	N		
<b>DRUG NAME</b>	STRENGTH	SIC	G/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 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 10 mg/kg IV every 3 weeks 10 mg/kg IV every 12 week Other:	x 4 doses s x 4 doses s	Quantity: Refills:
Zelboraf	240 mg	4 tablets PO twice daily Other:		Quantity: Refills:
Zolinza	100 mg	4 capsules PO once daily Other:		Quantity: Refills:
PRESCRIPTIO	NS DRUG NAM	ME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
Rx 1	Other:	Oth	er:	Quantity: Refills:
Rx 2	Other:	Oth	er:	Quantity: Refills:
Rx 3	Ondansetron Promethazine	☐ Oth	er:	Quantity: Refills:
Patient is interest	ted in patient support progra		RE NOT ALLOWED Ancillary supplies and k	
	6 PRESCRIBER	SIGNATURE REQUIRED	(STAMP SIGNATURE NOT	ALLOWED)
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution of DAW / May Not Substitute  Prescriber's Signature:			May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:Date:	
			ATTN: New York and Iowa	

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.

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