Oncology Oral Medications Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 3375 Koapaka Street, Suite D105, Honolulu, HI 96819

Phone: 1-808-254-2727
NCPDP: 1203417

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)
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: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____

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 _____
☐ Code: _____ Description _____ ☐ Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm BSA: _____ m^2

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

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Please Complete Patient and Prescriber Information

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

Patient Address:_____

Prescriber Name: _____ Prescriber Phone: _____

Medications

- ☐ Afinitor (everolimus)
- ☐ Afinitor Disperz (everolimus)
- ☐ Alecensa (alectinib)
- ☐ Balversa (erdafitinib)
- ☐ Bosulif (bosutinib)
- ☐ Braftovi (encorafenib)
- ☐ Cabometyx (cabozantinib)
- ☐ Cometriq (cabozantinib)
- ☐ Copiktra (duvelisib)
- ☐ Cotellic (cobimetinib)
- ☐ Cytoxan Capsules (cyclophosphamide)
- ☐ Daurismo (glasdegib)
- ☐ Erivedge (vismodegib)
- ☐ Erleada (apalutamide)
- ☐ Gleevec (imatinib mesylate)
- ☐ Gleostine (lomustine)
- ☐ Hycamtin Capsules (topotecan)
- ☐ Ibrance (palbociclib)
- ☐ Idhifa (enasidenib)
- ☐ Imkeldi (imatinib)
- ☐ Inlyta (axitinib)
- ☐ Inqovi (decitabine and cedazuridine)
- ☐ Inrebic (fedratinib)
- ☐ Iressa (gefitinib)
- ☐ Itovebi (inavolisib)
- ☐ Jakafi (ruxolitinib)
- ☐ Jayprica (pirtobrutinib)
- ☐ Kisqali (ribociclib)
- ☐ Lenvima (Lenvatinib)
- ☐ Lonsurf (trifluridine & tipiracil)
- ☐ Lorbrena (lorlatinib)
- ☐ Lumakras (sotorasib)
- ☐ Lynparza (olaparib)
- ☐ Mekinist (trametinib)
- ☐ Mektovi (binimetinib)
- ☐ Nerlynx (neratinib)
- ☐ Nexavar (sorafenib)
- ☐ Ninlaro (ixazomib)
- ☐ Nubeqa (darolutamide)
- ☐ Odomzo (sonidegib)
- ☐ Onureg (azacitidine)
- ☐ Pomalyst (pomalidomide)
- ☐ Purixan (mercaptopurine)
- ☐ Retevmo (selpercatinib)
- ☐ Revlimid (lenalidomide)
- ☐ Rozlytrek (entrectinib)
- ☐ Rubraca (rucaparib)
- ☐ Rydapt (midostaurin)
- ☐ Sprycel (dasatinib)
- ☐ Stivarga (regorafenib)
- ☐ Sutent (sunitinib malate)
- ☐ Tabrecta (capmatinib)
- ☐ Tafinlar (dabrafinib)
- ☐ Tagrisso (osimertinib)
- ☐ Talzenna (talazoparib)
- ☐ Tarceva (erlotinib)
- ☐ Targretin Capsules (bexarotene)
- ☐ Tasigna (nilotinib)
- ☐ Temodar Capsules (temozolomide)
- ☐ Thalomid (thalidomide)
- ☐ Tykerb (lapatinib)
- ☐ Vepesid Capsules (etoposide)
- ☐ Verzenio (abemaciclib)
- ☐ Vitrakvi (larotrectinib)
- ☐ Vizimpro (dacomitinib)
- ☐ Votrient (pazopanib)
- ☐ Xalkori (crizotinib)
- ☐ Xeloda (capecitabine)
- ☐ Xospata (gilteritinib)
- ☐ Xtandi (enzalutamide)
- ☐ Yonsa (abiraterone acetate)
- ☐ Zejula (niraparib)
- ☐ Zelboraf (vemurafenib)
- ☐ Zolinza (vorinostat)
- ☐ Zydelig (idelalisib)
- ☐ Zykadia (ceritinib)
- ☐ Zytiga (abiraterone)
- ☐ Other: _____

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.

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Patient Address:_____
Prescriber Name: _____ Prescriber Phone: _____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 2	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 3	☐ Anastrozole ☐ Letrozole ☐ Dexamethasone ☐ Prednisone ☐ Exemestane ☐ Zoladex ☐ Fulvestrant	☐ Other: _____	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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