

# Pomalyst/Revlimid/Thalomid Enrollment Form



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

### 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: \_\_\_\_\_ 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

☐ Female Child – Reproductive Potential

☐ Adult Female – NOT of Reproductive Potential

☐ Female Child – NOT of Reproductive Potential

☐ Adult Male

☐ 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: _____<br>Refills: _____ |
| RX 2          | <input type="checkbox"/> Other: _____  | Other: _____   | Quantity: _____<br>Refills: _____ |
| RX 3          | <input type="checkbox"/> Dexamethasone | Other: _____   | Quantity: _____<br>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.

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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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