

Oncology Oral Medications Enrollment Form



Fax Referral To: 1-855-297-1270

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

Phone: 1-888-280-1190

NCPDP: 4026325

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: _____ 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

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

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.

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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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