Pomalyst/Revlimid/Thalomid Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

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^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

Medications:
☐ Pomalyst (pomalidomide) ☐ Revlimid (lenalidomide) ☐ Thalomid (thalidomide)

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 2	☐ Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 3	☐ Dexamethasone	Other: _____	Quantity: _____ 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.