Men's Health Oncology Enrollment Form

CVS specialty®

Fax Referral To: 888-435-1256
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 855-539-4712

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

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):

☐ C61 Prostate Cancer
☐ Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

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Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
☐ Erleada	60 mg	☐ 4 tablets PO once daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Jevtana	60 mg	☐ Other: _____	Quantity: _____ Refills: _____
☐ Lynparza	150 mg	☐ 2 tablets PO twice daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Nubeqa	300 mg	☐ 2 tablets PO twice daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Rubraca	☐ 200 mg ☐ 250 mg ☐ 300 mg	☐ 2 tablets PO twice daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Talzenna	☐ 0.1 mg ☐ 0.25 mg ☐ 0.35 mg ☐ 0.5 mg	☐ 1 capsule PO once daily #30 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Xtandi	☐ 40 mg capsule ☐ 40 mg tablet	☐ 4 capsules PO once daily #120 ☐ 4 tablets PO once daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Xtandi	80 mg tablet	☐ 2 tablets PO once daily #60 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Yonsa	125 mg	☐ 4 tablets PO once daily #120 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Zytiga	☐ 250 mg ☐ 500 mg	☐ 4 tablets PO once daily #120 ☐ 2 tablets PO once daily #60 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Methylprednisolone	4 mg	☐ 1 tablet PO twice daily #60 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Prednisone	5 mg	☐ 1 tablet PO once daily #30 ☐ 1 tablet PO twice daily #60 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Prednisone	10 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ 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.

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