Oncology Oral Medications Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) Patient Name: _______ DOB: _____ _____City, State, ZIP Code: _____ Address: 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. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. _____ Alternate Phone: _____ If **Minor**, Parent/Caregiver/Guardian Name (Last, First): Relationship to minor: Email: ______ Last Four of SSN: _____ Primary Language: _____ 2 PRESCRIBER INFORMATION _____ State License #: Prescriber's Name: _____ NPI #: _____ DEA #: _____ Group or Hospital: _____

 NPI #: _____ DEA #: ____ Group or Hospital: _____

 Address: _____ City, State, ZIP Code: ______

 Phone: _____ Fax: ____ Contact Person: _____ Contact's Phone: ______

 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 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:** 5 PRESCRIPTION INFORMATION **Medications: Diagnosis:** Physician Auth #: _____ Physician Auth #: _____ Physician Auth #: _____ Date: _____ MDS D46.9 Revlimid REMS Program Date: _____ ☐ MM C90.00 Pomalyst REMS Program MCL C83.10 Thalomid REMS Program Date: **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

Phone: 1-800-896-1464

Oncology Oral Medications Enrollment Form Medications A-Z

Please Complete Patient and Prescriber Information							
Patient Name:					Patient DOB:		
Prescriber Name:					Prescriber Phone:		
<u>Medications</u>							
Afinitor (everolimus)		Lorbrena (lorlatinib)			Tagrisso (osimertinib)		
Afinitor Disperz (everolimus)		Lumakras (sotorasib)		Talzenna (talazoparib)			
Alecensa (alectinib)		Lynparza (olaparib)		Tarceva (erlotinib)			
Bosulif (bosutinib)		Mekinist (trametinib)		Targretin Capsules (bexarotene)			
Braftovi (encorafenib)		Mektovi (binimetinib)			Tasigna (nilotinib)		
Cabometyx (cabozantinib)		☐ Nerlynx (neratinib)			Temodar Capsules (temozolomide)		
Cometriq (cabozantinib)		Nexavar (sorafenib)			☐ Thalomid (thalidomide)		
Cotellic (cobimetinib)		Ninlaro (ixazomib)			Tykerb (lapatinib)		
Cytoxan Capsules (cyclophosphamide)		Nubeqa (darolutamide)		Vepesid Capsules (etoposide)			
Daurismo (glasdegib)		Odomzo (sonidegib)		Verzenio (abemaciclib)			
Erivedge (vismodegib)		Onureg (azacitidine)		Uitrakvi (larot	☐ Vitrakvi (larotrectinib)		
Erleada (apalutamide)		Piqray (alpelisib)			Uizimpro (dad	☐ Vizimpro (dacomitinib)	
Gavreto (pralsetinib)		Pomalyst (pomalidomide)			☐ Votrient (paz	Votrient (pazopanib)	
Gleevec (imatinib mesylate)		Purixan (mercaptopurine)			🗌 Xalkori (crizo	Xalkori (crizotinib)	
Hycamtin Capsules (topotecan)		Retevmo (selpercatinib)			🗌 Xeloda (cape	Xeloda (capecitabine)	
Ibrance (palbociclib)		Revlimid (lenalidomide)			Xtandi (enzalutamide)		
Idhifa (enasidenib)		Rozlytrek (entrectinib)			Yonsa (abiraterone acetate)		
☐ Inlyta (axitinib)		Rubraca (rucaparib)			Zejula (niraparib)		
Inqovi (decitabine and cedazuridine)		Rydapt (midostaurin)			Zelboraf (vemurafenib)		
Inrebic (fedratinib)		Scemblix (asciminib)			Zolinza (vorinostat)		
Iressa (gefitinib)		Sprycel (dasatinib)			Zydelig (idelalisib)		
Jakafi (ruxolitinib)		Stivarga (regorafenib)		Zykadia (ceri	Zykadia (ceritinib)		
Kisqali (ribociclib)		Sutent (sunitinib malate)		e)	Zytiga (abirat	Zytiga (abiraterone)	
Lenvima (lenvatinib)		Tabrecta (capmatinib)		☐ Other:			
Lonsurf (trifluridine & tipiracil)		Tafinlar (dabrafinib)					
PRESCRIPTIONS	DRUG NAME/ST	RENGTH		S	SIG/DIRECTIONS	QUANTITY/REFILLS	
RX 1		По		Other:		Quantity:	
RA I	Other	r:		•		Refills:	
RX 2	Other:		Other:			Quantity:	
100.2						Refills:	
	= =	Letrozole					
RX 3		Prednisone	Other:			Quantity:	
		Zoladex				Refills:	
☐ Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration							
Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)							
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /							
DAW / May Not Substitute		ot sabstitute / No SUDSI			substitute / Product Selection Permitted / titution Permissible		
Prescriber's Signature:		Date:		Pres	scriber'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 in two and accounts to the best firm upon ladge with comparing decorporation in the national provided provided above in two and accounts to the best firm upon ladge with comparing decorporation in the national provided above in two and accounts to the best firm upon ladge with comparing decorporation in the national provided above in two and accounts to the best firm upon ladge with a supervision of the national provided above in two and accounts to the best firm upon ladge with a supervision decorporation in the national provided above in two and accounts to the best firm upon ladge with a supervision decorporation in the national provided above in two and accounts to the best firm upon ladge with a supervision decorporation in the national provided above in the supervision decorporation and accounts to the ladge with a supervision decorporation and the supervision an							

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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