

# Oncology Oral Medications Hematologic Malignancies Enrollment Form



Fax Referral To: 1-877-232-5455

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

Phone: 1-800-896-1464

## 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. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 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)

### 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 – NOT of Reproductive Potential  
 Female Child – Reproductive Potential  Adult Male  
 Adult Female – NOT of Reproductive Potential  Male Child

#### Medications:

<input type="checkbox"/> Bosulif (bosutinib)	<input type="checkbox"/> Inrebic (fedratinib)	<input type="checkbox"/> Revlimid (lenalidomide)	<input type="checkbox"/> Thalomid (thalidomide)
<input type="checkbox"/> Daurismo (glasdegib)	<input type="checkbox"/> Jakafi (ruxolitinib)	<input type="checkbox"/> Rydapt (midostaurin)	<input type="checkbox"/> Zolinza (vorinostat)
<input type="checkbox"/> Gleevec (imatinib mesylate)	<input type="checkbox"/> Ninlaro (ixazomib)	<input type="checkbox"/> Scemblix (asciminib)	<input type="checkbox"/> Zydelig (idelalisib)
<input type="checkbox"/> Idhifa (enasidenib)	<input type="checkbox"/> Onureg (azacitidine)	<input type="checkbox"/> Sprycel (dasatinib)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Inqovi (decitabine and cedazuridine)	<input type="checkbox"/> Pomalyst (pomalidomide)	<input type="checkbox"/> Targretin Capsules (bexarotene)	
	<input type="checkbox"/> Purixan (mercaptopurine)	<input type="checkbox"/> Tassigna (nilotinib)	

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 2	<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____
RX 3	<input type="checkbox"/> 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.

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.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates. ©2022 CVS Specialty and/or one of its affiliates. 75-35450E 05/17/22