Oncology Dermatology Medication Enrollment Form

Medications A-O

(Braftovi, Cotellic, Erivedge, Keytruda, Mekinist, Mektovi, Odomzo, Opdivo, Opdualag)

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

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 _____
☐ Code: ____ Description _____ ☐ Code: ____ Description _____

Patient Clinical Information: Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
☐ Braftovi	☐ 50 mg ☐ 75 mg	☐ 450 mg PO once daily in combination with Mektovi 45 mg PO twice daily ☐ 300 mg PO once daily in combination with Erbitux ☐ Other: _____	Quantity:_____ Refills:_____
☐ Cotellic	20 mg	☐ 3 tablets PO once daily days 1-21, off 7 days. Recycle every 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Erivedge	150 mg	☐ 1 capsule PO once daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Keytruda	100 mg/4 mL	☐ 200 mg IV every 3 weeks ☐ 400 mg IV every 6 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Mekinist	☐ 2 mg ☐ 0.5 mg	☐ 1 tablet PO once daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Mektovi	15 mg	☐ 45 mg PO twice daily in combination with Braftovi 450 mg PO once daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Odomzo	200 mg	☐ 1 capsule PO once daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Opdivo	☐ 40 mg/4 mL ☐ 100 mg/10 mL ☐ 240 mg/24 mL	☐ 240 mg IV every two weeks ☐ 480 mg IV every four weeks ☐ 1 mg/kg IV every 3 weeks x 4 doses ☐ Other: _____	Quantity:_____ Refills:_____
☐ Opdualag (nivolumab and relatimab-rmbw)	☐ 240 mg-80 mg/20 mL	☐ 480 mg nivolumab and 160 mg relatlimab IV every 4 weeks	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.

Oncology Dermatology Medication Enrollment Form

Medications P-Z

(Poteligeo, Tafinlar, Tecentriq, Yervoy, Zelboraf, Zolinza)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
☐ Poteligeo	20 mg/5 mL	☐ 1 mg/kg IV Days 1, 8, 15, 22 x 1 cycle ☐ 1 mg/kg IV every 2 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tafinlar	☐ 50 mg ☐ 75 mg	☐ 2 capsules PO twice daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tecentriq	840 mg/14 mL	☐ 840 mg IV every 2 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 3 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 12 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Zelboraf	240 mg	☐ 4 tablets PO twice daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Zolinza	100 mg	☐ 4 capsules PO once daily ☐ Other: _____	Quantity:_____ Refills:_____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
Rx 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
Rx 2	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
Rx 3	☐ Ondansetron ☐ Promethazine	☐ 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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"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: _____**

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