

Men's Health Oncology Enrollment Form



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: _____ Address: _____ City, State, ZIP Code: _____

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: _____ DOB: _____ Gender: Male Female

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):

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: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Erleada	60 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Jevtana	60 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lynparza	150 mg	<input type="checkbox"/> 2 tablets PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Nubeqa	300 mg	<input type="checkbox"/> 2 tablets PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xtandi	<input type="checkbox"/> 40 mg capsule <input type="checkbox"/> 40 mg tablet	<input type="checkbox"/> 4 capsules PO once daily #120 <input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xtandi	80 mg tablet	<input type="checkbox"/> 2 tablets PO once daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yonsa	125 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zytiga	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> 2 tablets PO once daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Methylprednisolone	4 mg	<input type="checkbox"/> 1 tablet PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone	5 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> 1 tablet PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone	10 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____
 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) _____ DISPENSE AS WRITTEN (Date) _____
 X _____ X _____

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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