Oncology Injectable and Infused Medication Enrollment Form

CVS specialty™

Fax Referral To: 1-800-323-2445
Email Referral To: customerservicefax@caremark.com
Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
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: _____
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 _____
For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm BSA: _____ m^2

5 PRESCRIPTION INFORMATION

Medications:

☐ Abraxane® (paclitaxel)
☐ Alimta® (pemetrexed)
☐ Avastin® (bevacizumab)
☐ Besponsa® (inotuzumab ozogamicin)
☐ Docetaxel
☐ Enhertu® (fam-trastuzumab deruxtecan-nxki)
☐ Erwinaze® (asparaginase *Erwinia chrysanthemi*)
☐ Gamcitabine HCL
☐ Herceptin® (trastuzumab)
☐ Keytruda® (pembrolizumab)
☐ Lumoxiti® (moxetumomab)
☐ Mylotarg™ (gemtuzumab ozogamicin)
☐ Nyvepria™ (pegfilgrastim-apgf)
☐ Opdivo™ (nivolumab)
☐ Padcev™ (enfortumab vedotin-ejfv)
☐ Phesgo (pertuzumab, trastuzamab, and hyaluronidase-zzxf)
☐ Poteligeo™ (mogamulizumab)
☐ Rituxan® (rituximab)
☐ Rituxan Hycela® (rituximab and hyaluronidase human) injection
☐ Sarclisa® (isatuximab-irfc)
☐ Vectibix ® (panitumumab)
☐ Velcade® (bortezomib)
☐ Yervoy® (ipilimumab)
☐ Zepzelca™ (lurbinectedin)
☐ Zoledronic Acid
☐ Other: _____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 2	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 3	☐ 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 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 below, 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.