

Oncology Oral Medications Enrollment Form



Fax Referral To: 1-888-435-1256

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-855-539-4712

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 BSA: _____ m²

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 – Reproductive Potential

Adult Female – NOT of Reproductive Potential

Female Child – NOT of Reproductive Potential

Adult Male

Male Child

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Medications A-Z

Please Complete Patient and Prescriber Information

Patient Name: _____

Patient DOB: _____

Prescriber Name: _____

Prescriber Phone: _____

Medications

- | | | |
|---|--|--|
| <input type="checkbox"/> Afinitor (everolimus) | <input type="checkbox"/> Lorbrena (lorlatinib) | <input type="checkbox"/> Tagrisso (osimertinib) |
| <input type="checkbox"/> Afinitor Disperz (everolimus) | <input type="checkbox"/> Lumakras (sotorasib) | <input type="checkbox"/> Talzena (talazoparib) |
| <input type="checkbox"/> Alecensa (alectinib) | <input type="checkbox"/> Lynparza (olaparib) | <input type="checkbox"/> Tarceva (erlotinib) |
| <input type="checkbox"/> Bosulif (bosutinib) | <input type="checkbox"/> Mekinist (trametinib) | <input type="checkbox"/> Targretin Capsules (bexarotene) |
| <input type="checkbox"/> Braftovi (encorafenib) | <input type="checkbox"/> Mektovi (binimetinib) | <input type="checkbox"/> Tassigna (nilotinib) |
| <input type="checkbox"/> Cabometyx (cabozantinib) | <input type="checkbox"/> Nerlynx (neratinib) | <input type="checkbox"/> Temodar Capsules (temozolomide) |
| <input type="checkbox"/> Cometriq (cabozantinib) | <input type="checkbox"/> Nexavar (sorafenib) | <input type="checkbox"/> Thalomid (thalidomide) |
| <input type="checkbox"/> Cotellic (cobimetinib) | <input type="checkbox"/> Ninlaro (ixazomib) | <input type="checkbox"/> Tykerb (lapatinib) |
| <input type="checkbox"/> Cytoxan Capsules (cyclophosphamide) | <input type="checkbox"/> Nubeqa (darolutamide) | <input type="checkbox"/> Vepesid Capsules (etoposide) |
| <input type="checkbox"/> Daurismo (glasdegib) | <input type="checkbox"/> Odomzo (sonidegib) | <input type="checkbox"/> Verzenio (abemaciclib) |
| <input type="checkbox"/> Erivedge (vismodegib) | <input type="checkbox"/> Onureg (azacitidine) | <input type="checkbox"/> Vitkravi (larotrectinib) |
| <input type="checkbox"/> Erleada (apalutamide) | <input type="checkbox"/> Piqray (alpelisib) | <input type="checkbox"/> Vizimpro (dacomitinib) |
| <input type="checkbox"/> Gavreto (pralsetinib) | <input type="checkbox"/> Pomalyst (pomalidomide) | <input type="checkbox"/> Votrient (pazopanib) |
| <input type="checkbox"/> Gleevec (imatinib mesylate) | <input type="checkbox"/> Purixan (mercaptopurine) | <input type="checkbox"/> Xalkori (crizotinib) |
| <input type="checkbox"/> Hycamtin Capsules (topotecan) | <input type="checkbox"/> Retevmo (selpercatinib) | <input type="checkbox"/> Xeloda (capecitabine) |
| <input type="checkbox"/> Ibrance (palbociclib) | <input type="checkbox"/> Revlimid (lenalidomide) | <input type="checkbox"/> Xtandi (enzalutamide) |
| <input type="checkbox"/> Idhifa (enasidenib) | <input type="checkbox"/> Rozlytrek (entrectinib) | <input type="checkbox"/> Yonsa (abiraterone acetate) |
| <input type="checkbox"/> Inlyta (axitinib) | <input type="checkbox"/> Rubraca (rucaparib) | <input type="checkbox"/> Zejula (niraparib) |
| <input type="checkbox"/> Inqovi (decitabine and cedazuridine) | <input type="checkbox"/> Rydapt (midostaurin) | <input type="checkbox"/> Zelboraf (vemurafenib) |
| <input type="checkbox"/> Inrebic (fedratinib) | <input type="checkbox"/> Scemblix (asciminib) | <input type="checkbox"/> Zolanza (vorinostat) |
| <input type="checkbox"/> Iressa (gefitinib) | <input type="checkbox"/> Sprycel (dasatinib) | <input type="checkbox"/> Zydelig (idelalisib) |
| <input type="checkbox"/> Jakafi (ruxolitinib) | <input type="checkbox"/> Stivarga (regorafenib) | <input type="checkbox"/> Zykadia (ceritinib) |
| <input type="checkbox"/> Kisqali (ribociclib) | <input type="checkbox"/> Sutent (sunitinib malate) | <input type="checkbox"/> Zytiga (abiraterone) |
| <input type="checkbox"/> Lenvima (lenvatinib) | <input type="checkbox"/> Tabrecta (capmatinib) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lonsurf (trifluridine & tipiracil) | <input type="checkbox"/> Tafenlar (dabrafenib) | |

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
RX 2	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
RX 3	<input type="checkbox"/> Anastrozole <input type="checkbox"/> Letrozole <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Prednisone <input type="checkbox"/> Exemestane <input type="checkbox"/> Zoladex <input type="checkbox"/> Fulvestrant	<input type="checkbox"/> 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)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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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