Oncology Dermatology Medication Enrollment Form

Medications A-O

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

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

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

PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: 0 Phone (to primary # provided below) 0 Text (to cell # provided below) 0 Email (to email provided below)

Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship Patient: _____

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 ☐ 3mg/kg IV every two weeks ☐ 6mg/kg 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: _____Patient Phone Number_____

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:_____

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