

# Non-Small Cell Lung Cancer 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: \_\_\_\_\_ Gender:  Male  Female  
 Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_  
 Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  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/Guardian Name (Last, First): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### 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: \_\_\_\_\_ m<sup>2</sup>  
 Biomarker(s):  ALK+  BRAF V600E  EGFR +  EGFR/T790M+  KRAS G12C+  METex14+  NTRK1/2/3+  RET+  
 ROS1+  PD-L1 <1%  PD-L1 ≥1%-49%  PD-L1 ≥ 50%  No actionable molecular marker

### 5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Avastin	<input type="checkbox"/> 100 mg/4 mL <input type="checkbox"/> 400 mg/16 mL	<input type="checkbox"/> 15 mg/kg IV every three weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Alecensa	150 mg	<input type="checkbox"/> 4 capsules PO twice daily #240 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Augtyro	40 mg	<input type="checkbox"/> 4 capsules PO once daily for 14 days, then increase to 4 capsules twice daily thereafter <input type="checkbox"/> 4 capsules PO twice daily #240 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Braftovi	75 mg	<input type="checkbox"/> 6 capsules PO once daily #180 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cyramza	<input type="checkbox"/> 100 mg/10 mL <input type="checkbox"/> 500 mg/50 mL	<input type="checkbox"/> 10 mg/kg IV once every two weeks <input type="checkbox"/> 10 mg/kg IV once every three weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Enhertu	100 mg	<input type="checkbox"/> 5.4 mg/kg IV once every three weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Gavreto	100 mg	<input type="checkbox"/> 4 capsules PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Imfinzi	<input type="checkbox"/> 120 mg/2.4 mL <input type="checkbox"/> 500 mg/10 mL	<input type="checkbox"/> 10 mg/kg IV every 2 weeks <input type="checkbox"/> 1500 mg IV every 4 weeks <input type="checkbox"/> 20 mg/kg IV every 3 weeks for 4 cycles then every 4 weeks <input type="checkbox"/> 1,500 mg IV every 3 weeks for 4 cycles then every 4 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Imjudo	<input type="checkbox"/> 25 mg/1.25 mL <input type="checkbox"/> 300 mg/15 mL	<input type="checkbox"/> 75 mg IV every 3 weeks for 4 cycles and a 5 <sup>th</sup> dose at week 16 <input type="checkbox"/> 1mg/kg IV every 3 weeks for 4 cycles and a 5 <sup>th</sup> dose at week 16 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Iressa	250 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Keytruda	100 mg/4 mL	<input type="checkbox"/> 200 mg IV every three weeks <input type="checkbox"/> 400 mg IV every six weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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.

# Non-Small Cell Lung Cancer Medications Enrollment Form

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Libtayo	350 mg/7 mL	<input type="checkbox"/> 350 mg IV every three weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lorbrena	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lumakras	120 mg	<input type="checkbox"/> 8 tablets PO once daily #240 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Mekinist	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 2 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Mektovi	15 mg	<input type="checkbox"/> 3 tablets PO twice daily #180 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Opdivo	<input type="checkbox"/> 40 mg/4 mL <input type="checkbox"/> 100 mg/10 mL <input type="checkbox"/> 120 mg/12 mL <input type="checkbox"/> 240 mg/24 mL	<input type="checkbox"/> 240 mg IV every two weeks <input type="checkbox"/> 480 mg IV every four weeks <input type="checkbox"/> 360 mg IV every three weeks <input type="checkbox"/> 3 mg/kg IV every two weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Retevmo	<input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg	<input type="checkbox"/> 2 capsules PO twice daily #120 <input type="checkbox"/> 3 capsules PO twice daily #180 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rozlytrek	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> 3 capsules PO once daily #90 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rybrevant	350 mg/7 mL	<input type="checkbox"/> 1050 mg IV once weekly for 4 weeks then every 2 weeks starting at week 5 <input type="checkbox"/> 1400 mg IV once weekly for 4 weeks then every 2 weeks starting at week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tabrecta	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> 2 tablets PO twice daily #112 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tafinlar	<input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/> 2 capsules PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tagrisso	<input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tarceva	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> 3 tablets PO once daily #90 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tecentriq	<input type="checkbox"/> 840 mg/14 mL <input type="checkbox"/> 1,200 mg/20 mL	<input type="checkbox"/> 1,200 mg IV every two weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Vitakvi	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg	<input type="checkbox"/> 1 capsule PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

**Please Complete Patient and Prescriber Information**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

**5 PRESCRIPTION INFORMATION**

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Vizimpro	<input type="checkbox"/> 15 mg <input type="checkbox"/> 45 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xalkori	<input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg	<input type="checkbox"/> 1 capsule PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yervoy	<input type="checkbox"/> 50 mg/10 mL <input type="checkbox"/> 200 mg/40 mL	<input type="checkbox"/> 1 mg/kg IV every six weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zykadia	150 mg	<input type="checkbox"/> 3 tablets PO once daily #90 <input type="checkbox"/> Other: _____	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: _____

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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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