Oncology Dermatology Medication Enrollment Form

Medications A-O

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

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 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.

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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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