Non-Small Cell Lung Cancer Medications Enrollment Form

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 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^2

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
☐ Avastin	☐ 100 mg/4 mL ☐ 400 mg/16 mL	☐ 15 mg/kg IV every three weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Alecensa	150 mg	☐ 4 capsules PO twice daily #240 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Augtyro	40 mg	☐ 4 capsules PO once daily for 14 days, then increase to 4 capsules twice daily thereafter ☐ 4 capsules PO twice daily #240 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Braftovi	75 mg	☐ 6 capsules PO once daily #180 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Cyramza	☐ 100 mg/10 mL ☐ 500 mg/50 mL	☐ 10 mg/kg IV once every two weeks ☐ 10 mg/kg IV once every three weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Enhertu	100 mg	☐ 5.4 mg/kg IV once every three weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Gavreto	100 mg	☐ 4 capsules PO once daily #120 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Imfinzi	☐ 120 mg/2.4 mL ☐ 500 mg/10 mL	☐ 10 mg/kg IV every 2 weeks ☐ 1500 mg IV every 4 weeks ☐ 20 mg/kg IV every 3 weeks for 4 cycles then every 4 weeks ☐ 1,500 mg IV every 3 weeks for 4 cycles then every 4 weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Imjudo	☐ 25 mg/1.25 mL ☐ 300 mg/15 mL	☐ 75 mg IV every 3 weeks for 4 cycles and a 5th dose at week 16 ☐ 1mg/kg IV every 3 weeks for 4 cycles and a 5th dose at week 16 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Iressa	250 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Keytruda	100 mg/4 mL	☐ 200 mg IV every three weeks ☐ 400 mg IV every six weeks ☐ 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
☐ Libtayo	350 mg/7 mL	☐ 350 mg IV every three weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Lorbrena	☐ 25 mg ☐ 100 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Lumakras	120 mg	☐ 8 tablets PO once daily #240 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Mekinist	☐ 0.5 mg ☐ 2 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Mektovi	15 mg	☐ 3 tablets PO twice daily #180 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Opdivo	☐ 40 mg/4 mL ☐ 100 mg/10 mL ☐ 120 mg/12 mL ☐ 240 mg/24 mL	☐ 240 mg IV every two weeks ☐ 480 mg IV every four weeks ☐ 360 mg IV every three weeks ☐ 3 mg/kg IV every two weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Retevmo	☐ 40 mg ☐ 80 mg	☐ 2 capsules PO twice daily #120 ☐ 3 capsules PO twice daily #180 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Rozlytrek	☐ 100 mg ☐ 200 mg	☐ 3 capsules PO once daily #90 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Rybrevant	350 mg/7 mL	☐ 1050 mg IV once weekly for 4 weeks then every 2 weeks starting at week 5 ☐ 1400 mg IV once weekly for 4 weeks then every 2 weeks starting at week ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tabrecta	☐ 150 mg ☐ 200 mg	☐ 2 tablets PO twice daily #112 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tafinlar	☐ 50 mg ☐ 75 mg	☐ 2 capsules PO twice daily #120 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tagrisso	☐ 40 mg ☐ 80 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tarceva	☐ 25 mg ☐ 100mg ☐ 150 mg	☐ 1 tablet PO once daily #30 ☐ 3 tablets PO once daily #90 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tecentriq	☐ 840 mg/14 mL ☐ 1,200 mg/20 mL	☐ 1,200 mg IV every two weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Vitrakvi	☐ 25 mg ☐ 100 mg	☐ 1 capsule PO twice daily #60 ☐ 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
☐ Vizimpro	☐ 15 mg ☐ 45 mg ☐ 30 mg	☐ 1 tablet PO once daily #30 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Xalkori	☐ 200 mg ☐ 250 mg	☐ 1 capsule PO twice daily #60 ☐ Other: _____	Quantity:_____ Refills:_____
☐ Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 1 mg/kg IV every six weeks ☐ Other: _____	Quantity:_____ Refills:_____
☐ Zykadia	150 mg	☐ 3 tablets PO once daily #90 ☐ Other: _____	Quantity:_____ Refills:_____
RX 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 2	☐ 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 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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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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