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: __________ 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)
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: ______________________
Email: ______________________ Last Four of SSN: __________ Primary Language: __________
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): ______________________
Relationship to minor: ______________________

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: ____ m^2

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: ____________Patient Phone Number: ______________

Prescriber Name: __________________________________Prescriber Phone: ____________________________________

Medications

- ☐ Afinitor (everolimus)
- ☐ Afinitor Disperz (everolimus)
- ☐ Alecensa (alectinib)
- ☐ Augtyro (repotrectinib)
- ☐ Balversa (erdafitinib)
- ☐ Bosulif (bosutinib)
- ☐ Braftovi (encorafenib)
- ☐ Cabometyx (cabozantinib)
- ☐ Cometriq (cabozantinib)
- ☐ Copiktra (duvelisib)
- ☐ Cotellic (cobimetinib)
- ☐ Cytoxan Capsules (cyclophosphamide)
- ☐ Daurismo (glasdegib)
- ☐ Erivedge (vismodegib)
- ☐ Erleada (apalutamide)
- ☐ Gavreto (pralsetinib)
- ☐ Gleevec (imatinib mesylate)
- ☐ Gleostine (lomustine)
- ☐ Hycamtin Capsules (topotecan)
- ☐ Ibrance (palbociclib)
- ☐ Idhifa (enasidenib)
- ☐ Inlyta (axitinib)
- ☐ Inqovi (decitabine and cedazuridine)
- ☐ Inrebic (fedratinib)
- ☐ Iressa (gefitinib)
- ☐ Jakafi (ruxolitinib)
- ☐ Jayprica (pirtobrutinib)
- ☐ Kisqali (ribociclib)
- ☐ Lenvima (Lenvatinib)
- ☐ Lonsurf (trifluridine & tipiracil)
- ☐ Lorbrena (lorlatinib)
- ☐ Lumakras (sotorasib)
- ☐ Lynparza (olaparib)
- ☐ Mekinist (trametinib)
- ☐ Mektovi (binimetinib)
- ☐ Nerlynx (neratinib)
- ☐ Nexavar (sorafenib)
- ☐ Ninlaro (ixazomib)
- ☐ Nubeqa (darolutamide)
- ☐ Odomzo (sonidegib)
- ☐ Onureg (azacitidine)
- ☐ Piqray (alpelisib)
- ☐ Pomalyst (pomalidomide)
- ☐ Purixan (mercaptopurine)
- ☐ Retevmo (selpercatinib)
- ☐ Revlimid (lenalidomide)
- ☐ Rozlytrek (entrectinib)
- ☐ Rubraca (rucaparib)
- ☐ Rydapt (midostaurin)
- ☐ Scemblix (asciminib)
- ☐ Sprycel (dasatinib)
- ☐ Stivarga (regorafenib)
- ☐ Sutent (sunitinib malate)
- ☐ Tabrecta (capmatinib)
- ☐ Tafinlar (dabrafinib)
- ☐ Tagrisso (osimertinib)
- ☐ Talzenna (talazoparib)
- ☐ Tarceva (erlotinib)
- ☐ Targretin Capsules (bexarotene)
- ☐ Tasigna (nilotinib)
- ☐ Temodar Capsules (temozolomide)
- ☐ Thalomid (thalidomide)
- ☐ Truseltiq (infigratinib)
- ☐ Tykerb (lapatinib)
- ☐ Vepesid Capsules (etoposide)
- ☐ Verzenio (abemaciclib)
- ☐ Vitrakvi (larotrectinib)
- ☐ Vizimpro (dacomitinib)
- ☐ Votrient (pazopanib)
- ☐ Xalkori (crizotinib)
- ☐ Xeloda (capecitabine)
- ☐ Xospata (gilteritinib)
- ☐ Xtandi (enzalutamide)
- ☐ Yonsa (abiraterone acetate)
- ☐ Zejula (niraparib)
- ☐ Zelboraf (vemurafenib)
- ☐ Zolinza (vorinostat)
- ☐ Zydelig (idelalisib)
- ☐ Zykadia (ceritinib)
- ☐ Zytiga (abiraterone)
- ☐ Other: __________________

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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Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ____________ Patient Phone Number: ______________

Prescriber Name: __________________________________ Prescriber Phone: ____________________________________

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: ________________________	☐ Other: ________________________________	Quantity:_________ Refills:___________
RX 2	☐ Other: ________________________	☐ Other: ________________________________	Quantity:_________ Refills:___________
RX 3	☐ Anastrozole ☐ Letrozole ☐ Dexamethasone ☐ Prednisone ☐ Exemestane ☐ Zoladex ☐ Fulvestrant	☐ Other: ________________________________	Quantity:_________ Refills:___________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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