Oncology Supportive Therapy Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 NCPDP: 4026325

Six Simple Steps to Submitting a Referral

-						
Patient Information (Complete of Patient Name:		DOB:		Gender: 🗌 Male 🔲 Femal		
Address:	City, State, ZIP Code:					
Preferred Contact Met	hods: 🗌 Phone (to prir	mary # provided below) \square Text (to cell	# provided below) 🗌	Email (to email provided below)		
		act via text or email, Specialty Pharmac				
Primary Phone:		Alterna	ite Phone:			
		Last Four of SSN:				
If Minor , Parent/Careo	jiver/Guardian Name	(Last, First): R e	elationship to mine	or:		
_						
2 PRESCRIBER II	NFORMATION					
Prescriber's Name:		Stat	e License #:			
NPI #: D	DEA #:	Group or Hospital:				
Address:		City, State, Z Contact Person:	IP Code:			
Phone:	Fax:	Contact Person:	Co	ntact's Phone:		
INSURANCE IN						
– 4 DIAGNOSIS AI	ND CLINICAL IN	IFORMATION		is form, if available (front and back)		
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4 DIAGNOSIS AN Needs by Date: Diagnosis (ICD-10):	ND CLINICAL IN Ship to: [IFORMATION Patient Office Other:				
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PRESCRIPTION INFORMATION PRESCRIPTION INFORMATION STRENGTH DOSE& DIRECTIONS QUANTITY/REFILLS	atient Name: _	Please Complete Patient and Prescriber Information ont Name:Patient DOB:Patient Phone:					
Aranesp Single-dose Vials: 25 mcg 40 mcg 60 mcg 100 mcg 150 mcg 200 mcg 300 mcg 500 mcg 500 mcg 500 mcg 500 mcg 100 mcg 100 mcg 100 mcg 500 mc							
Aranesp	PRESCRI	PTION INFORMATION					
_ 25 mcg	MEDICATION	STRENGTH	DO	SE & DIRECTIONS	QUANTITY/REFILLS		
Epogen	☐ Aranesp	25 mcg	(Circle: IV or SC) Inject the entire conte	ents of vial/syringe every 3 weeks			
Procrit/ Epogen Biosimilar Retacrit Refacrit Patient is interested in patient support programs Tamps SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) Procrit/ Epogen Biosimilar 10,000 u/mL (SDV) 10,000 u/mL (SDV) 10,000 u/mL-2 mL vial (MDV) Circle: IV or SC) Donce a Week 3 Times a Week Other: The procrit of the entire contents of Yvial (Circle: IV or SC) Donce a Week 3 Times a Week Other: Donce a Week 3 Times a Week Other: The procrit of the entire contents of Yvial (Circle: IV or SC) Donce a Week 3 Times a Week Other: The procrit of the entire contents of Yvial (Circle: IV or SC) Donce a Week 3 Times a Week Other: Donce a Week 3 Times a Week Other: The procrit of the entire contents of Yvial (Circle: IV or SC) Donce a Week 3 Times a Week Other: Donce a Week 7 Times a Week Product Selection Permitted / Substitution Permissible	OR	☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV)	(Circle: IV or SC) Once a Week 3 Times a Week Other: Multi-dose Vial (MDV): Inject mL (units) (Circle: IV or SC)		Refills:		
*Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute *May Substitute / Product Selection Permitted / Substitution Permissible	Epogen Biosimilar	☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV)	(Circle: IV or SC) ☐ Once a Week ☐ 3 Times a Week ☐ Other: mL (units) (Circle: IV or SC)		Refills:		
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute May Substitute / Product Selection Permitted / Substitution Permissible	Patient is interested	d in patient support programs	STAMP SIGNATURE NOT A	ALLOWED Ancillary supplies and kits	provided as needed for administration		
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute May Substitute / Product Selection Permitted / Substitution Permissible		6 PRESCRIBER SIGNAT	URE REQUIRED (ST	TAMP SIGNATURE NOT ALLO	WED)		
Prescriber's Signature:Date:	DAW / May Not Su	ten" / Brand Medically Necessary / Do Not S bstitute	ubstitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	-		
	Prescriber's S	Signature:	Date:	Prescriber's Signature:	Date:		

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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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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			Prescriber Information	
			Patient Phone:_	
	ne:	P	rescriber Phone:	
	PTION INFORMATION			
MEDICATION		DO	SE & DIRECTIONS	QUANTITY/REFILLS
Granix	300 mcg Vial 480 mcg Vial 300 mcg Prefilled Syringe 480 mcg Prefilled Syringe		g once a day fordays	Quantity: Refills:
Leukine	250 mcg vial (lyophilized) 500 mcg/mL vial (liquid)	Administermcg (Circle: IV or SC) Other:	once a day fordays	Quantity: Refills:
☐ Neulasta	6 mg Prefilled Syringe		ter chemotherapy, every days loses 1 week apart	Quantity: Refills:
Neulasta Biosimilars Fulphila Fylnetra Nyvepria Stimufend Udenyca Ziextenzo	6 mg Prefilled Syringe		iter chemotherapy, every days	Quantity: Refills:
☐ Neulasta OnPro Kit	6 mg Prefilled Syringe with on- body injector	Apply to skin the day of chemo to Inject 6 mg SC day after chemotherapy, every days Other:		Quantity: Refills:
Neupogen	300 mcg Vial 480 mcg Vial 300 mcg Prefilled Syringe 480 mcg Prefilled Syringe	Administer mcg once a day fordays (Circle: IV or SC) Other:		Quantity: Refills:
Neupogen Biosimilars Nivestym Releuko Zarxio	300 mcg Vial (n/a for Zarxio) 480 mcg Vial (n/a for Zarxio) 300 mcg Prefilled Syringe 480 mcg Prefilled Syringe	(Circle: IV or SC)	g once a day fordays	Quantity: Refills:
Nplate	125 mcg (SDV) 250 mcg (SDV) 500 mcg (SDV)	☐ Inject _ mcg subcutaneously as one-time dose ☐ Inject _ mcg subcutaneously once weekly ☐ Other:		Quantity: Refills:
Rolvedon	13.2 mg Prefilled Syringe	☐ Inject 13.2 mg SC day after chemotherapy, every days ☐ Other:		Quantity: Refills:
Patient is interested	id in patient support programs PRESCRIBER SIGNAT	STAMP SIGNATURE NOT A	ALLOWED Ancillary supplies and kits p TAMP SIGNATURE NOT ALLO	orovided as needed for administration
DAW / May Not S	tten" / Brand Medically Necessary / Do Not S ubstitute	ubstitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	
Prescriber's	Signature:	Date:	Prescriber's Signature:	Date:
			ATTN: New York and Iowa provide	

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