

Non-Small Cell Lung Cancer Medications Enrollment Form Medications A-L

(Avastin, Alecensa, Cyramza, Gavreto, Imfinzi, Iressa, Keytruda, Libtayo, Lorbrena)

Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com

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



Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

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: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

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: _____ m²

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"/> 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"/> 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 two weeks <input type="checkbox"/> 20 mg/kg IV every three weeks <input type="checkbox"/> 1,500 mg IV every four weeks <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: _____
<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: _____

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)

<p><small>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</small></p> <p>Prescriber's Signature: _____ Date: _____</p>	<p><small>May Substitute / Product Selection Permitted / Substitution Permissible</small></p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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

Medications L-Z

(Lumakras, Mekinist, Opdivo, Retevmo, Rozlytrek, Tabrecta, Tafinlar, Tagrisso, Tarceva, Tecentriq, Vizimpro, Xalkori, Yervoy, Zykadia)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

DRUG NAME	STRENGTH	DOSE/DIRECTIONS	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"/> 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"/> 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: _____
<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

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"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	

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