Oncology Oral Medications Hematologic Malignancies Enrollment Form

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): ______________________
Relationship to minor: ______________________
Email: ______________________ Last Four of SSN: ________ Primary Language: ______________

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 ______________

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

Medications:
☐ Bosulif (bosutinib)
☐ Daurismo (glasdegib)
☐ Gleevec (imatinib mesylate)
☐ Idhifa (enasidenib)
☐ Inqovi (decitabine and cedazuridine)
☐ Inrebic (fedratinib)
☐ Jakafi (ruxolitinib)
☐ Ninlaro (ixazomib)
☐ Onureg (azacitidine)
☐ Pomalyst (pomalidomide)
☐ Purixan (mercaptopurine)
☐ Revlimid (lenalidomide)
☐ Rydapt (midostaurin)
☐ Scemblix (asciminib)
☐ Sprycel (dasatinib)
☐ Targretin Capsules (bexarotene)
☐ Tasigna (nilotinib)
☐ Thalomid (thalidomide)
☐ Zolinza (vorinostat)
☐ Zydelig (idelalisib)
☐ Other: ______________

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: ___________	Other: ______________________	Quantity: ______ Refills: ______
RX 2	☐ Other: ___________	Other: ______________________	Quantity: ______ Refills: ______
RX 3	☐ Dexamethasone	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.

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.
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