Urology Oral Medications 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: ______________________ Address: ______________________ City, State, ZIP: ______________________

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: ________________ DOB: ________________ Gender: ☐ Male ☐ Female

Email: ______________________ Last Four of SSN: __________ Primary Language: ________________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________ State License #: ______________________

NPI #: ______________ DEA #: ______________ Group or Hospital: ______________________

Address: ______________________ City, State, ZIP: ______________________

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):

☐ C61 Prostate Cancer

☐ Code: ________ Description: ______________________

Patient Clinical Information:

Allergies: ______________________ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
☐ Erleada	60 mg	☐ 4 tablets PO once daily #120 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Lynparza	150 mg	☐ 2 tablets PO twice daily #120 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Nubeqa	300 mg	☐ 2 tablets PO twice daily #120 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Xtandi	☐ 40 mg capsule ☐ 40 mg tablet	☐ 4 capsules PO once daily #120 ☐ 4 tablets PO once daily #120 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Xtandi	80 mg tablet	☐ 2 tablets PO once daily #60 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Zytiga	☐ 250 mg ☐ 500 mg	☐ 4 tablets PO once daily #120 ☐ 2 tablets PO once daily #60 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Prednisone	5 mg	☐ 1 tablet PO twice daily #60 ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Other: ________	☐ Other: ________	☐ Other: ______________	Quantity: ________ Refills: ________

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: ______________________

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

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X______________________ X______________________

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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