Oncology Injectable and Infused Medication Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: customerservicefax@caremark.com
Phone: 1-800-237-2767

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):

☐ Code: _________ Description __________________________ ☐ Code: ___________ Description _________________________

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies: _____________________________ Weight: ______lb/kg Height: ______in/cm BSA: _____________ m²

5 PRESCRIPTION INFORMATION

Medications:

- ☐ Abraxane® (paclitaxel)
- ☐ Alimta® (pemetrexed)
- ☐ Avastin® (bevacizumab)
- ☐ Besponsa® (inotuzumab ozogamicin)
- ☐ Docetaxel
- ☐ Enhertu® (fam-trastuzumab deruxtecan-nxki)
- ☐ Erwinaze® (asparaginase *Erwinia chrysanthemi*)
- ☐ Gamcitabine HCL
- ☐ Herceptin® (trastuzumab)
- ☐ Keytruda® (pembrolizumab)
- ☐ Lumoxiti® (moxetumomab)
- ☐ Mylotarg™ (gemtuzumab ozogamicin)
- ☐ Nyvepria™ (pegfilgrastim-apgf)
- ☐ Opdivo™ (nivolumab)
- ☐ Padcev™ (enfortumab vedotin-ejfv)
- ☐ Phesgo (pertuzumab, trastuzamab, and hyaluronidase-zzxf)
- ☐ Poteligeo™ (mogamulizumab)
- ☐ Rituxan® (rituximab)
- ☐ Rituxan Hycela® (rituximab and hyaluronidase human) injection
- ☐ Sarclisa® (isatuximab-irfc)
- ☐ Vectibix ® (panitumumab)
- ☐ Velcade® (bortezomib)
- ☐ Yervoy® (ipilimumab)
- ☐ Zoledronic Acid
- ☐ Other: _________________________

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _______________	☐ Other: ________________________________	Quantity:_________ Refills:___________
RX 2	☐ Other: _______________	☐ Other: ________________________________	Quantity:_________ Refills:___________
RX 3	☐ Other: _______________	☐ Other: ________________________________	Quantity:_________ Refills:___________

☐ 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)
X____

DISPENSE AS WRITTEN (Date)
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 below, 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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