

# 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)

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#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm BSA: \_\_\_\_\_ m<sup>2</sup>

### 5 PRESCRIPTION INFORMATION

#### Medications:

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

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	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: _____
RX 3	<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

### 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 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.

**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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