Oncology Oral Medications Enrollment Form

Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101

Phone: 877-814-8447
NCPDP: 2008301

Six Simple Steps to Submitting a Referral

❶ PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________
Address: ______________________
City, State, ZIP: ______________________
Preferred Contact Method: ☐ 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: __________ ☐ Home ☐ Cell ☐ Work
Alternate Phone: __________ ☐ Home ☐ Cell ☐ Work
DOB: __________ Gender: ☐ Male ☐ Female
Email: ______________________
Last Four of SSN: __________ Primary Language: __________

❷ PRESCRIBER INFORMATION

Prescriber's Name: ______________________
State License #: __________ NPI #: __________
DEA #: __________
Group or Hospital: ______________________
Address: ______________________
City, State, ZIP: ______________________
Phone: ______________________
Fax: ______________________
Contact Person: ______________________
Contact's Phone: ______________________

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

❹ 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 www.CVSspecialty.com/ICD10

Patient Clinical Information:

Allergies: ______________________
Weight: ______ lbs/kg Height: ______ Inches/cm
BSA: ______ m^2

❺ 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

☐ Afinitor® (everolimus)
☐ Afinitor® Disperz (everolimus)
☐ Alecensa® (alectinib)
☐ Alunbrig™ (brigatinib)
☐ Bosulif® (bosutinib)
☐ Cabometyx™ (cabozantinib)
☐ Cotellic™ (cobimetinib)
☐ Erivedge® (vismodegib)
☐ Erleada™ (apalutamide)
☐ Farydak® (panobinostat)
☐ Gleevec® (imatinib mesylate)
☐ Hycamtin® Capsules (topotecan)
☐ Ibrance® (palbociclib)
☐ Idhifa® (enasidenib)
☐ Inlyta® (axitinib)
☐ Iressa® (gefitinib)
☐ Jakafi® (ruxolitinib)
☐ Kisqali® (ribociclib)
☐ Lonsurf® (trifluridine & tipiracil)
☐ Mekinist® (trametinib)
☐ Nerlynx™ (neratinib)
☐ Nexavar® (sorafenib)
☐ Ninlaro® (ixazomib)
☐ Odomzo® (sonidegib)
☐ Pomalyst® (pomalidomide)
☐ Other: ______________________
☐ Purixan® (mercaptopurine)
☐ Revlimid® (lenalidomide)
☐ Rubraca™ (rucaparib)
☐ Rydapt® (midostaurin)
☐ Sprycel® (dasatinib)
☐ Stivarga® (regorafenib)
☐ Sutent® (sunitinib malate)
☐ Tafinlar® (dabrafinib)
☐ Tagrisso™ (osimertinib)
☐ Tarceva® (erlotinib HCl)
☐ Targretin® Capsules (bexarotene)
☐ Tasigna® (nilotinib)
☐ Temodar® Capsules (temozolomide)
☐ Thalomid® (thalidomide)
☐ Tykerb® (lapatinib)
☐ Verzenio™ (abemaciclib)
☐ Votrient® (pazopanib)
☐ Xalkori® (crizotinib)
☐ Xeloda® (capecitabine)
☐ Xtandi® (enzalutamide)
☐ Zelboraf® (vemurafenib)
☐ Zolinza® (vorinostat)
☐ Zykadia™ (ceritinib)
☐ Zytiga® (abiraterone)

Rx 1	**Drug Name/Strength:** **Quantity:**	**Sig/Directions:** **Refills:**
Rx 2	**Drug Name/Strength:** **Quantity:**	**Sig/Directions:** **Refills:**
Rx 3	☐ Dexamethasone ☐ Exemastane ☐ Letrozole ☐ Prednisone **Sig/Directions:**	**Strength:** **Quantity:** **Refills:**

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

❻ X______________________ (Date)
PRODUCT SUBSTITUTION PERMITTED

X______________________ (Date)
DISPENSE AS WRITTEN

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