## **Oncology Dermatology Medication Enrollment Form**

## **Medications A-O**

(Braftovi, Cotellic, Erivedge, Keytruda, Mekinist, Mektovi, Odomzo, Opdivo, Opdualag)



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

**Six Simple Steps to Submitting a Referral PATIENT INFORMATION** (Complete or include demographic sheet) Patient Name: 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. \_\_\_\_ Alternate Phone: \_\_\_ If **Minor**, Parent/Caregiver/Guardian Name (Last, First): \_\_\_\_ Relationship to minor: Last Four of SSN: Primary Language: Email: 2 PRESCRIBER INFORMATION Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_ Group or Hospital: \_\_\_ City, State, ZIP Code: \_\_\_\_\_Contact's Phone: \_\_\_\_ Address: Phone: 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 \_\_\_\_\_ Code: \_\_\_\_ Description \_\_\_\_\_ Code: \_\_\_\_ Description \_\_\_ Patient Clinical Information: Allergies: \_\_\_\_\_ Weight: \_\_\_\_lb/kg Height: \_\_\_\_in/cm 5 PRESCRIPTION INFORMATION **DRUG NAME** SIG/DIRECTIONS **QUANTITY/REFILLS** STRENGTH 450 mg PO once daily in combination with Mektovi 45 mg PO twice daily ☐ 50 mg Ouantity: ☐ Braftovi 300 mg PO once daily in combination with Erbitux 75 mg Refills: Other: Quantity:\_\_\_ 3 tablets PO once daily days 1-21, off 7 days. Recycle every 28 days. ☐ Cotellic 20 ma Refills:\_\_\_ 1 capsule PO once daily
Other: Quantity:\_ ☐ Erivedge 150 mg Refills:\_\_\_ Quantity:\_\_\_ 200 mg IV every 3 weeks 400 mg IV every 6 weeks 100 ma/4 mL Refills: 1 tablet PO once daily 2 mg Quantity:\_\_\_\_ Mekinist ☐ 0.5 mg Refills: Quantity:\_\_ 45 mg PO twice daily in combination with Braftovi 450 mg PO once daily Mektovi 15 mg Refills: Other: Ouantity: 1 capsule PO once daily Odomzo 200 mg Refills: Other: Quantity:\_\_\_ 240 mg IV every two weeks 480 mg IV every four weeks 40 mg/4 mL Refills:\_\_\_ ☐ 100 mg/10 mL 1 mg/kg IV every 3 weeks x 4 doses Opdivo 240 mg/24 mL Other: Opdualag Quantity:\_\_\_ 480 mg nivolumab and 160 mg relatlimab IV every 4 weeks 240 mg-80 mg/20 mL (nivolumab and relatimab-rmbw) Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: \_ Prescriber's Signature: \_ \_ ATTN: New York and Iowa providers, please submit electronic prescription CA. MA. NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

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.

## **Oncology Dermatology Medication Enrollment Form**

## **Medications P-Z**

(Poteligeo, Tafinlar, Tecentriq, Yervoy, Zelboraf, Zolinza)

	Ple	ase Complete Patient a	and Prescriber Information	
Patient Nam	e:		Patient DOB:	
Prescriber N	lame:		Prescriber Phone:	
5 PRESCRIP	TION INFORMATIO	N		
DRUG NAME	STRENGTH	SIG	G/DIRECTIONS	QUANTITY/REFILLS
Poteligeo	20 mg/5 mL	1 mg/kg IV Days 1, 8, 15, 22 x 1 cycle 1 mg/kg IV every 2 weeks Other:		Quantity: Refills:
☐ Tafinlar	☐ 50 mg ☐ 75 mg	2 capsules PO twice daily Other:		Quantity: Refills:
☐ Tecentriq	840 mg/14 mL	840 mg IV every 2 weeks Other:		Quantity: Refills:
Yervoy	☐ 50 mg/10 mL ☐ 200 mg/40 mL	☐ 3 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 3 weeks x 4 doses ☐ 10 mg/kg IV every 12 weeks ☐ Other:		Quantity: Refills:
Zelboraf	240 mg	4 tablets PO twice daily Other:		Quantity: Refills:
Zolinza	100 mg	4 capsules PO once daily Other:		Quantity: Refills:
PRESCRIPTIO	ONS DRUG NAM	ME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
Rx 1		Othe	ər:	Quantity:
Rx 2	Other:	Othe	er:	Refills: Quantity: Refills:
Rx 3 Ondansetron Promethazine		☐ Other:		Quantity: Refills:
Patient is interes	sted in patient support progra	ms STAMP SIGNATUR	ENOT ALLOWED Ancillary supplies and kits p	provided as needed for administration
	6 PRESCRIBER	SIGNATURE REQUIRED	(STAMP SIGNATURE NOT AL	.LOWED)
DAW / May Not Subs	titute	/ Do Not Substitute / No Substitution /Date:	May Substitute / Product Selection Permitted. Substitution Permissible Prescriber's Signature:	
CA, MA, NC & PR: Int	erchange is mandated unless Pres	scriber writes the words "No Substitution" _	ATTN: New York and Iowa prov	iders, 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.

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