

# Men's Health Oncology Enrollment Form



Fax Referral To: 1-877-232-5455

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

Phone: 1-800-896-1464

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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.*

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): \_\_\_\_\_

**Relationship to minor:** \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

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

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## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Erleada	60 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Jevtana	60 mg	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Lynparza	150 mg	<input type="checkbox"/> 2 tablets PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Nubeqa	300 mg	<input type="checkbox"/> 2 tablets PO twice daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xtandi	<input type="checkbox"/> 40 mg capsule <input type="checkbox"/> 40 mg tablet	<input type="checkbox"/> 4 capsules PO once daily #120 <input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Xtandi	80 mg tablet	<input type="checkbox"/> 2 tablets PO once daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Yonsa	125 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Zytiga	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> 4 tablets PO once daily #120 <input type="checkbox"/> 2 tablets PO once daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Methylprednisolone	4 mg	<input type="checkbox"/> 1 tablet PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone	5 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> 1 tablet PO twice daily #60 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Prednisone	10 mg	<input type="checkbox"/> 1 tablet PO once daily #30 <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	<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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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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