Oral Oncology Referral Form

Phone: 877-985-MEDS(6337) Fax: 866-679-7131

Patient Information OR Attach Face Sheet					
First Name:	**Middle Initial:**		**Last Name:**		
Date of Birth:	**Gender:** ___ Male ___ Female		**SSN:**		
Street Address:	**City:**		**State:**	**Zip Code:**	
Home Phone:	**Work Phone:**		**Cell Phone:**		

Insurance Information OR Attach Insurance Information				
Rx Card Ins Name:	**ID#:**	BIN:	PCN:	Phone#:
Primary Ins Name:	ID#:	Group #:		Phone#:
Secondary Ins Name:	ID#:	Group #:		Phone#:

Prescription Information			
POMALYST	**REVLIMID**	**THALOMID**	**Risk Category**
Dosing: (circle one) **1mg | 2mg | 3mg |4mg**	**Dosing: (circle one)** **2.5mg |5mg |10mg |15mg |20mg |25mg**	**Dosing: (circle one)** **50mg|100mg|150mg|200mg**	☐ Adult Female, **NOT** of Reproductive Potential
Directions:	Directions:	Directions:	☐ Adult Female, **Reproductive Potential**
Qty:	Qty:	Qty:	☐ Adult Male
Rest Period:	Rest period:	Rest period:	☐ Male Child
Auth Number:	Auth number:	Auth number:	☐ Female Child, **NOT** of reproductive Potential
Date:	Date:	Date:	
Confirmation:	Confirmation:	Confirmation:	☐ Female Child, **Reproductive Potential**
Date:	Date:	Date:	

Drug List

☐ Afinitor	☐ Idhifa	☐ Promacta	☐ Verzenio	**STRENGTH:**
☐ Alecensa	☐ Imatinib	☐ Rydapt	☐ Votrient	
☐ Alunbrig	☐ Inlyta	☐ Sprycel	☐ Xalkori	**DIRECTIONS (SIG)/CYCLE:**
☐ Bosulif	☐ Intron A	☐ Stivarga	☐ Xeloda	
☐ Cabometyx	☐ Iressa	☐ Sutent	☐ Xtandi	
☐ Cotellic	☐ Jadenu	☐ Sylatron	☐ Zelboraf	
☐ Emend	☐ Kisqali	☐ Tafinlar	☐ Zykadia	
☐ Erivedge	☐ Lonsurf	☐ Tarceva	☐ Zytiga	**QUANTITY:** **REFILLS:**
☐ Erleada	☐ Mekinist	☐ Tagrisso	☐ Other: _____	
☐ Exjade	☐ Nexavar	☐ Tasigna		
☐ Farydak	☐ Ninlaro	☐ Temodar		Prescriber must write "Brand Medically Necessary" in his/her own handwriting to prevent substitution.
☐ Ibrance	☐ Odomzo	☐ Tykerb		

Secondary/Other Prescription: Drug Name:	**Strength:**
Directions/cycle:	**Qty:** **Refills:**

Clinical Information					
Primary Diag:	ICD-10:	Secondary Diag:	ICD-10:	Wt:	Ht:
Allergies:		Failed Therapies:			
Patient medication list (or attach separately):					

Prescriber Information					
Prescriber First Name:		Last Name:		Facility Name:	
DEA:	State License #:	NPI:	UPIN:	Office Email:	
Office Address:	City:	State:	Zip Code:		
Office Phone:	Office Fax:	Office Contact:			

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *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.*

Prescriber Signature:	**Date:**