

### Patient Information OR Attach Face Sheet

First Name:	Middle Initial:	Last Name:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> Adult Female, NOT of Reproductive Potential
Directions:	Directions:	Directions:	<input type="checkbox"/> Adult Female, Reproductive Potential
Qty:	Qty:	Qty:	<input type="checkbox"/> Adult Male
Rest Period:	Rest period:	Rest period:	<input type="checkbox"/> Male Child
Auth Number:	Auth number:	Auth number:	<input type="checkbox"/> Female Child, NOT of Reproductive Potential
Date:	Date:	Date:	<input type="checkbox"/> Female Child, Reproductive Potential
Confirmation:	Confirmation:	Confirmation:	<input type="checkbox"/> Female Child, Reproductive Potential
Date:	Date:	Date:	

### Drug List

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

<b>Secondary/Other Prescription: Drug Name:</b>	<b>Strength:</b>
<b>Directions/cycle:</b>	<b>Qty: Refills:</b>

### 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.

<b>Prescriber Signature:</b>	<b>Date:</b>
------------------------------	--------------