OPTUM®

Oncology – Revlimid, Pomalyst, Thalomid Enrollment Form

Specialty Pharmacy Enrollment Form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona**

PATIENT INFORMATION *Please complete the following or* ***send patient demographic sheet***

Patient Name _____ DOB _____ Last Four of SS# _____ Gender _____

Address _____ City, State, ZIP _____

Home Phone _____ Alternate Phone _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber's Name _____

NPI _____ DEA _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

Prescriber's Name _____

NPI _____ Office Contact _____

Prescriber's Name _____

NPI _____ Office Contact _____

Prescriber's Name _____

NPI _____ Office Contact _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ ICD-10 _____ Description _____

Test Results: **WNL:**

☐ SCr/CrCl _____ ☐ Yes ☐ No

☐ LFTs _____ ☐ Yes ☐ No

☐ Hgb/Hct _____ ☐ Yes ☐ No

☐ WBC _____ ☐ Yes ☐ No

☐ Electrolytes _____ ☐ Yes ☐ No

☐ CT/MRI/Other _____ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Prior Therapies _____

Concomitant Medications _____

Additional Comments _____

Current Cycle # _____ Total # of Cycles _____

☐ Pomalyst® Physician Authorization # _____ Diagnosis: ☐ MMC90.00 ☐ Date _____

☐ Revlimid® Physician Authorization # _____ Diagnosis: ☐ MDS D45.9 ☐ MMC90.00 ☐ Date _____

☐ Thalomid® Physician Authorization # _____ Diagnosis: ☐ MMC90.00 ☐ Date _____

Pregnancy Category: ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Adult Male

☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential ☐ Male Child

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Therapy Cycle	Quantity
☐ Revlimid				
☐ Pomalyst				
☐ Thalomid				

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date: _____ Supervising Physician Signature: _____ Date: _____

Electronic or digital signatures not accepted.