Autoimmune IV 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):

- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M32.1 Systemic lupus erythematosus (SLE)
- ☐ M32.14 Glomerular disease in systemic lupus erythematosus
- ☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
- ☐ L40.50 Arthropathic Psoriasis, Unspecified
- ☐ L40.59 Other Psoriatic Arthropathy
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ K50.00 Crohn's Disease of Small Intestine Without Complications
- ☐ K50.10 Crohn's Disease of Large Intestine Without Complications
- ☐ K50.80 Crohn's Disease of Small & Large Intestine Without Complications
- ☐ K50.90 Crohn's Disease, Unspecified, Without Complications
- ☐ K51.00 Ulcerative (chronic) pancolitis without complications
- ☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- ☐ K51.50 Left sided colitis without complications
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ Other Code: ______________ Description: ________________

Patient Clinical Information:

Allergies: ________________ Weight: __________lb/kg Height: __________in/cm
TB test Result ☐ Positive ☐ Negative Date of test: __/__/____
Positive ANA or anti-dsDNA test? ☐ Yes ☐ No Date of test: __/__/____
Hepatitis status: ________________
New to therapy? ☐Yes ☐ No If no, next dose due: _______

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Autoimmune IV Enrollment Form

Medications A-D

(Actemra, Avsola, Benlysta)

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ______________________________

Prescriber Name: ______________________________ Prescriber Phone: ______________________________

Patient Clinical Information:

Allergies: ________________ Weight: ________________________ lb/kg Height: ____________ In/cm

TB test Result ☐ Positive ☐ Negative Date of test: __/__/____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks ☐ Other: ______________________	Quantity: _____ Refills: ______
☐ Actemra	162 mg/0.9 mL prefilled syringe	☐ For patients weighing <100 kg: Inject 162 mg SC every other week, followed by an increase to every week based on clinical response ☐ For patients weighing ≥ 100 kg: Inject 162 mg SC every week.	Quantity: _____ Refills: ______
☐ Avsola	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _______mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _______mg) every 4, 6 or 8 weeks (circle one) ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Other: ______________________	Quantity: _______ # of 100 mg vial(s) Refills: ________
☐ Benlysta	☐ 120 mg 5 mL vial ☐ 400 mg 20 mL vial	☐ Induction Dose: 10 mg/kg IV (Dose = ____mg) at 2-week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour.	Quantity: _____ vials 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 **Prescriber's Signature: ____________________ Date: ________**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: ____________________ Date: _______**
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________	**ATTN: New York and Iowa providers,** 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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Autoimmune IV Enrollment Form
Medications E-Q
(Entyvio, Inflectra, Infliximab, Orencia)

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ______________________________
Prescriber Name: ______________________________ Prescriber Phone: ______________________________

Patient Clinical Information:
Allergies: ____________________ Weight: ______________________________ lb/kg Height: ____________ In/cm
TB test Result ☐ Positive ☐ Negative Date of test: __/__/____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Entyvio	300 mg in a single dose vial in individual carton	☐ Induction Dose: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 300 mg infused IV over 30 minutes every 8 weeks ☐ Other: ______________________________	Quantity: _______ Refills: _________
☐ Inflectra ☐ Infliximab	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _______mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _______mg) every 4, 6 or 8 weeks (circle one) ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Other: ______________________________	Quantity: _______ # of 100 mg vial(s) Refills: _________
☐ Orencia	250 mg vial	☐ Infuse __ mg at weeks 0, 2 and 4, then every 4 weeks thereafter ☐ Other: ______________________________	Quantity: ________ Refills: _________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ______________	**ATTN: New York and Iowa providers,** please submit electronic prescription

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Autoimmune IV Enrollment Form

Medications R-Z

(Remicade, Renflexis, Rituxan, Saphnelo, Simponi ARIA, Stelara)

Please Complete Patient and Prescriber Information

Patient Name: ____ Patient DOB: ____

Prescriber Name: ____Prescriber Phone:______________________________________

Patient Clinical Information:

Allergies: _______________________Weight: _____________________________________lb/kg Height:______________In/cm

TB test Result ☐ Positive ☐ Negative Date of test: __/__/____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Remicade ☐ Renflexis	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _______mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _______mg) every 4, 6 or 8 weeks (circle one) ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _______mg) every 8 weeks ☐ Other: ________________________________	Quantity: _______ # of 100 mg vial(s) Refills: _________
☐ Rituxan	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks ☐ Other: _________________________________	Quantity: _____ vials Refills: ________
☐ Saphnelo	300 mg/2 mL (150 mg/mL)	☐ 300 mg IV over a 30-minute period, every 4 weeks ☐ Other: _________________________________	Quantity: ______ vials Refills: ________
☐ Simponi ARIA	50 mg/4 mL in a single use vial	☐ Initial Dose: Inject SC 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at week 0, followed by 100 mg at week 2 and then 100 mg every 4 weeks ☐ Maintenance Dose: Inject SC 100 mg every 4 weeks ☐ Other: ________________________________	Quantity: _______ Refills: _________
☐ Stelara	130 mg/26 mL (5 mg/mL) IV single-dose vial	Single IV Induction Dose: ☐ 55 kg or less 260 mg at week 0: # of vials to be used 2 ☐ more than 55 kg to 85 kg 390 mg at week 0: # of vials to be used 3 ☐ more than 85 kg 520 mg at week 0: # of vials to be used 4 ☐ Other: ________________________________	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _______________ **ATTN: New York and Iowa providers,** please submit electronic prescription

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Autoimmune IV Enrollment Form

Nursing Medications

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ______________________________

Prescriber Name: ______________________________ Prescriber Phone: ______________________________

Patient Clinical Information:

Allergies: ________________ Weight: ________________ lb/kg Height: __________ In/cm

TB test Result ☐ Positive ☐ Negative Date of test: __/__/____

5 PRESCRIPTION INFORMATION

Complete Items below, required for Home Infusion:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity: _______ Refills: ________
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _______ Refills: ________
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: ________	Other: ________	☐ Other: ______________________________	Dose will be rounded to the nearest vial size
☐ Flush Orders	☐ Peripheral Access ☐ Central Venus Access	☐ 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for maintenance ☐ Heparin _____ units per mL flush with _____ units as final flush and as directed	Send quantity sufficient for medication days' supply
Additional Medication: ____________	________	______________________________	____________

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