Autoimmune IV Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

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: _____

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.

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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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

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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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