Multiple Sclerosis IV Infusion Enrollment Form

CVS specialty®

Fax Referral To: 1-855-592-6890 **Phone:** 1-866-526-4984
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

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 ☐ Coram Ambulatory Infusion Suite ☐ Other: _____
☐ Infusion Site: Name: _____ Address: _____
(Please include street address, suite #, city, state, ZIP)

Diagnosis (ICD-10):
☐ G35 Multiple Sclerosis (MS) ☐ Other Code: _____ Description _____

If MS, please indicate type:
☐ Primary progressive MS (PPMS)
☐ Relapsing-remitting MS (RRMS)
☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

Height: _____in/cm Weight: _____lb/kg Allergies: _____

MS drug(s) not able to use:
Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____
Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Nursing:
Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Lemtrada	NA	Please complete an MS One to One/Lemtrada enrollment form and indicate CVS Specialty as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).	Quantity: 0 Refills: 0
☐ Ocrevus	300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300 mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. ☐ Maintenance: Infuse 600 mg IV over approximately 2 to 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed.	Quantity: ☐ 2 vials ☐ Other: _____ Refills: _____
Diluent: ☐ Sodium Chloride	0.9%	Use as directed.	Quantity: ☐ 250 mL (induction) ☐ 500 mL (maintenance) Refills:_____
Premed Corticosteroid: ☐ Methylprednisolone ☐ Other: _____	☐ Other: _____	☐ 100mg administered IV approximately 30 minutes prior to each Ocrevus infusion. ☐ Other: _____	Quantity:_____ Refills:_____
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
☐ Tysabri	NA	Please complete an MS Touch/Tysabri enrollment form and indicate CVS Specialty as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).	Quantity: 0 Refills: 0
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____

Complete Items below, required for Home Infusion/Coram AIS:

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:_____

☐ 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.