Soliris 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):

☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)
☐ G70.0 generalized Myasthenia Gravis (gMG)
☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

Patient is required to have a meningitis vaccine at least two weeks prior to starting therapy. Date of Vaccine: _____

Patient Administration Information:

IV access type: ☐ Peripheral ☐ PICC ☐ Port

Patient to be infused: ☐ Hospital/Clinic ☐ CVS Specialty to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol ☐ Other

Is this a 1st dose? ☐ Yes ☐ No **If yes, where is the patient to be infused for first dose?** ☐ MD office with MDO staff ☐ Hospital/Clinic ☐ Home by HC nurse ☐ Other: _____

Pump infusion required? ☐ Yes ☐ No **Specialty Pharmacy to coordinate nursing for home care** ☐ Yes ☐ No

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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
☐ Soliris	300 mg/30 mL vial (10 mg/mL)	For Treatment of PHN: ☐ **Dose Titration** – Month 1: Administer 600 mg via IV infusion every 7 days for 4 weeks For Treatment of aHUS: ☐ **Dose Titration** – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks For Treatment of gMG: ☐ **Dose Titration** – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	Quantity: 4-week supply Refills: 0
☐ Soliris	300 mg/30 mL vial (10 mg/mL)	For Treatment of PHN: ☐ **Maintenance Dosing:** Administer 900 mg via IV infusion every 2 weeks starting week 5 For Treatment of aHUS: ☐ **Maintenance Dosing:** Administer 1,200 mg via IV infusion every 2 weeks starting Week 5 For Treatment of gMG: ☐ **Maintenance Dosing:** Administer 1,200 mg via IV infusion every 2 weeks starting Week 5	Quantity: ☐ 4-weeks supply ☐ 12-weeks supply ☐ Other: _____ Refills: 1-year supply
☐ Soliris	300 mg/30 mL vial (10 mg/mL)	Other: _____	Quantity: _____ Refills: _____

MEDICATION	STRENGTH/VOLUME	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Normal Saline Flush 0.9%	10 mL	Use to flush the line before and/or after the infusion per physician orders Note: If patient has a port Sodium Chloride Posiflush SF will be dispensed	Quantity: _____ Refills: _____
☐ Normal Saline Flush 0.9%	250 mL bag	Dilute Soliris dose with equal amount of sodium chloride 0.9% to a final concentration of 5 mg/mL	Quantity Sufficient
☐ Heparin 10 u/mL OR ☐ Heparin 100 u/mL	☐ 3mL ☐ 5mL	Flush the line after the infusion per physician orders	Quantity: _____ Refills: _____
☐ Diphenhydramine	Other: _____	Other: _____	Quantity: _____ Refills: _____
☐ Epi-pen 0.3 mg (adult)	0.3 mg	Inject 0.3 mg IM/SQ as needed for anaphylaxis or as directed then seek immediate medical attention/call 911. If symptoms continue, may repeat in 5-15 minutes.	Quantity: _____ Refills: _____
☐ Epi-pen Junior 0.15 mg (15-29 kg patients)	0.15 mg	Inject 0.15 mg IM/SQ as needed for anaphylaxis or as directed then seek immediate medical attention/call 911. If symptoms continue, may repeat in 5-15 minutes. (patients <30 kg)	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.