

Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727 NCPDP: 1203417

		er writes the words " No Substitution "		nd Iowa providers, please s	
DAW / May Not Substitu		Not Substitute / No Substitution / Date:	May Substitute / Product S Substitution Permissible Prescriber's Signat		Date:
		D (STAMP SIGNATURE N	-		
Patient is interested in patient		STAMP SIGNATURE NOT ALLOWED		ry supplies and kits provided as need	
Other	Strength:	☐ Dose:			Quantity: Refills:
(unbranded version of Hyrimoz)	40 mg/0.4 mL PFS (with needle guard)	one week after initial dose Inject 160 mg SC on Day 1 (days), 80 mg on Day 15, then 4 Inject 160 mg SC on Day 1 (days), 80 mg on Day 15, then 8	single-dose or split ove 10 mg every week starti single-dose or split ove	r two consecutive ng on Day 29 r two consecutive	Quantity: 28 days 84 days Refills:
Adalimumab-	☐ 40 mg/0.4 mL PEN	☐ Inject 40 mg SC every weel☐ Inject 40 mg SC every othe☐ Inject 80 mg SC every othe☐ Inject 80 mg SC on Day 1, for	r week r week	/ other week starting	
Adalimumab- aacf (Unbranded Idacio)		☐ Inject 40 mg SC every weel☐ Inject 40 mg SC every othe☐ Inject 80 mg SC every othe☐ Inject 80 mg Day 1, followed week after initial dose	k r week r week	week starting one	28 days 84 days Refills:
	STRENGTH		SE & DIRECTIONS		OUANTITY/REFIL
	e/Other Infusion Clinic: Dr ON INFORMATION	rug only for facility administrati	on		
Home Infusion/Cor	am AIS: Diluents, Flushes	hree doses to be given in cons, Supplies, Nursing Services fo	or drug administration	therapy teach train.	
Site of Care: 🔲 Ho	me Infusion* 🔲 Coram	Ambulatory Infusion Suite (AIS	6)* Prescriber's O	ffice** 🔲 Other Info	usion Clinic
		th Infusion nurse visit as necess	sary? Tyes No		
reatment status: L Nursing and Adr		tinuation of therapy; date of las	st treatment//_	Needs by date: _	
Prior therapy, treatn	nent dates, and reason(s)	for discontinuation:			
Weight:	lb/kg Height: _	In/cm TE	B Test Result:	 Date:	
Patient Clinical I Illergies:					
	· · ·	Other Code: Des	cription:		
		L63.8 Other alopecia areat			
L40.54 Juvenile	psoriatic arthritis L40.5	9 Other Psoriatic Arthropathy	L40.8 Other		
L28.1 Prurigo No L40.4 Guttate Ps		60 Arthropathic Psoriasis, Unsp	pecified		
_		Psoriasis Vulgaris] L40.1 Generalized Pu	ıstular Psoriasis	
Diagnosis (ICD-1		only to ration C	moe 🗀 oulei		
DIAGNOSIS A	AND CLINICAL INFO				
		se fax copy of prescription a			
Phone:	Fax	City, State, Z Contact Person:	Co	ntact's Phone:	
лгі #	_ DEA # Gr	City State 7			
rescriber's Name:	:	roup or Hospital:			
	INFORMATION		O		
		t, First):	_ Relationship to pati	ent:	
mail:		Last Four c	of SSN: Pri	mary Language:	
			Alternate Phone:		
		narmacy will attempt to contact b		u data rates appty. Mes	ssage frequency varies.
		e phone number(s) and email add t your prescription(s), account, ar			
		mary # provided below) 🗌 Te>			
ddress:			, State, ZIP Code:		
		e or include demographic sh		Gender: 🗌 Ma	ale Female
PATIENT INFO	ORMATION (Complet	te or include demographic sh	mitting a Referra eet)		

		Patient , Prescriber an			
			Patient		
Prescriber Name: _ Patient Clinical Info		Prescribe	er Phone:		
Allergies:					
Weight:		In/cm TBT	est Result:	Date:	
	ON INFORMATION				_
MEDICATION	STRENGTH	DOSE &	directions	QUANTITY/REF	FILLS
Adalimumab- fkjp (unbranded version of Hulio)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week☐ Inject 40 mg SC every other v☐ Inject 80 mg SC every other v☐ Inject 80 mg SC on Day 1, folloone week after initial dose☐ Inject 160 mg SC on Day 1 (sir days), 80 mg on Day 15, then 40☐ Inject 160 mg SC on Day 1 (sir days), 80 mg on Day 15, then 80	veek veek owed by 40 mg every other we ogle-dose or split over two cons mg every week starting on Day ogle-dose or split over two cons	Quantity: 28 days secutive 84 days 729 Refills:	
Amjevita (adalimumab-atto)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week☐ Inject 40 mg SC every other v☐ Inject 80 mg SC every other v☐ Inject 80 mg Day 1, followed bweek after initial dose☐ Inject 160 mg SC on Day 1 (given consecutive days), 80 mg on Day other week dosing two weeks lat	veek veek by 40 mg every other week star ven in one day or split over two v 15. Begin 40 mg weekly or 80	Quantity: Tting one 28 days 84 days Refills:	
Avsola	100 mg vial	☐ Induction Dose: Infuse IV at 5 0, 2, 6 and every 8 weeks therea: ☐ Maintenance Dose: Infuse IV (Dose =mg) every 8 weeks	mg/kg (Dose =mg) at we ter	eks Quantity: # of 100 mg vial(s) Refills:)
☐ Bimzelx	☐ 2 x 160 mg/mL PEN☐ 2 x 160 mg/mL PFS	Loading Dose: ☐ Inject 320 mg (2 x 160 mg/ml Maintenance Dose: ☐ Inject 320 mg (2 x 160 mg/ml Patients ≥ 120 kg (264lbs) may co ☐ Inject 320 mg (2 x 160 mg/ml	.) SC every 8 weeks onsider:	Loading Dose: Quantity: 28 Days Refills: 4 Maintenance Dose Quantity: 28 Days 28 Days 56 Days Refills:	<u>e</u> :
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Psoriasis Loading Dose:		Quantity: 1 Kit Refills: 0	
☐ Cimzia	200 mg/1 mL prefilled syringe	Psoriasis Maintenance Dose: 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week 200 mg every other week Psoriatic Arthritis Maintenance Dose: 200 mg every other week 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks		Quantity: Refills:	
Other	Strength:	Dose:		Quantity: Refills:	
Patient is interested in pa		STAMP SIGNATURE NOT ALLOWED		es and kits provided as needed for administ	stration
PRESCRIBER 1	SIGNATURE REQU	IRED (STAMP SIGNATU	RE NOT ALLOWED)		
/ May Not Substitute Prescriber's Signa	ature:	Not Substitute / No Substitution / DAW Date: pr writes the words "No Substitution"	May Substitute / Product Selection Substitution Permissible Prescriber's Signature:		

	Please Complete Patic	ent , Prescriber an	d Patient Clini	cal Information	
Patient Name:	Pa	atient DOB:		Patient Phone:	
		Prescribe	er Phone:		
Patient Clinical Informa					
Allergies:	lb/kg Height:	In /one TD T	ant Donults	Datas	
5 PRESCRIPTION	tb/kg Height:	IN/CM 1B I	est Result:	Date:	
			OOE O DIDECTION	10	OLIANTITY/DEELLO
MEDICATION	STRENGTH		OSE & DIRECTION	15	QUANTITY/REFILLS
☐ Cosentyx	☐ 75 mg/0.5 mL PFS ☐ 150 mg/mL PEN ☐ 150 mg/mL PFS ☐ 150 mg/mL PEN ☐ 150 mg/mL PFS ☐ 300 mg/2 mL PEN	Loading Dose: Inject 75 mg SC on Inject 150 mg SC or Inject 300 mg SC or Maintenance Dose: Inject 75 mg SC or Inject 75 mg SC or Inject 150 mg SC or Inject 150 mg SC or Inject 300 mg SC or Inject 300 mg SC or Inject 300 mg SC or	Neeks 0, 1, 2, 3 n Weeks 0, 1, 2, 3 Week 4, then every 4 ery 4 weeks n Week 4, then every ery 4 weeks n Week 4, then every very 4 weeks	4 weeks thereafter	Loading Dose: Quantity: 28 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills:
☐ Dupixent	☐ PFS 300 mg/2 mL prefilled syringe ☐ Pen* 300 mg/2 mL prefilled pen *Comes in cartons of 2	Initial Prurigo Nodularis Inject 600 mg SC (2 SC every other week Maintenance Prurigo N Inject 300 mg SC every	s <u>Dose:</u> 2-300 mg injections) Iodularis Dose:	initially then 300 mg	Quantity: 28-day supply 84-day supply Other:Day supply Refills: 1 year Other:Refills
☐ Enbrel	50 mg/mL Mini 50 mg/mL PEN 50 mg/mL PFS 25 mg/0.5 mL PFS 25 mg/0.5 mL Vial	Loading Dose: Inject 50 mg SC twi 3 months, then mainter Maintenance Dose: Inject 50 mg SC one Inject mg Sc	nance dosing ce weekly	ys apart) for	Loading Dose: Quantity: 84 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills:
☐ Hadlima	☐ 40 mg/0.4 mL PEN☐ 40 mg/0.8 mL PEN☐ 40 mg/0.4 mL PFS☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC eve ☐ Inject 40 mg SC eve ☐ Inject 80 mg SC eve ☐ Inject 80 mg SC on week starting one weel ☐ Inject 160 mg SC or consecutive days), 80 starting on Day 29 ☐ Inject 160 mg SC or consecutive days), 80 week starting on Day 2	ery other week ery other week Day 1, followed by 40 k after initial dose n Day 1 (single-dose omg on Day 15, then 4 n Day 1 (single-dose omg on Day 15, then 8	or split over two 00 mg every week or split over two	Quantity: 28 days 84 days Refills:
Other	Strength:	Dose:			Quantity: Refills:
Patient is interested in patient: PRESCRIBER SIG	support programs STAMPS GNATURE REQUIRED (SIGNATURE NOT ALLOWED			ded as needed for administration
"Dispense As Written" / Brar / May Not Substitute Prescriber's Signatur	nd Medically Necessary / Do Not Substi	itute / No Substitution / DAW	May Substitute / Produ Substitution Permissib Prescriber's Sign	uct Selection Permitted /	Date:submit electronic prescription

	Please Comple	ete Patient , Prescriber an	d Patient Clinical Informatio	<u>n</u>
		Patient DOB:	Patient Phone:	
	ne:	Prescribe	r Phone:	
Patient Clinical				
Allergies:	lb/kg Height	In /are TD T		
			est Result: Date: _	
	TION INFORMATION			
MEDICATION	STRENGTH		DIRECTIONS	QUANTITY/REFILLS
☐ Hulio	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	one week after initial dose Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 80 mg	ek ed by 40 mg every other week starting e-dose or split over two consecutive	Quantity: 28 days 84 days Refills:
☐ Humira	☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL PFS ☐ 80 mg/0.8 mL Pen	subsequent doses Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single	ek O mg every other week on day 8 and e-dose or split over two consecutive	28 days 84 days Refills:
☐ Hyrimoz	40 mg/0.4 mL PEN 80 mg/0.8 mL PEN 40 mg/0.4 mL PFS (with needle guard) Psoriasis Starter Kit (1-80 mg and 2-40 mg PEN)	one week after initial dose Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single	ek ed by 40 mg every other week starting e-dose or split over two consecutive	28 days 84 days Refills:
☐ Idacio	☐ 40 mg/0.8 mL PEN ☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose		28 days 84 days Refills:
□ Ilumya	100 mg/mL prefilled syringe	Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks.		Quantity: Refills:
☐ Inflectra		☐ Induction Dose: Infuse IV at 5 mg	g/kg	Quantity:
☐ Infliximab	100 mg vial	(Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks		# of 100 mg vial(s) Refills:
Other	Strength:	□ Dose:		Quantity: Refills:
	d in patient support programs BER SIGNATURE REQ	STAMP SIGNATURE NOT ALLOWED UIRED (STAMP SIGNATURE)	, , , ,	ovided as needed for administration
/ May Not Substitu Prescriber's \$	te Signature:	Do Not Substitute / No Substitution / DAW Date: riber writes the words "No Substitution"	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:ATTN: New York and Iowa providers, pleas	

	Please Compl	ete Patient , Prescriber an	d Patient Clinical Information	
Patient Name: _			Patient Phone:	
		Prescribe	r Phone:	
Patient Clinical				
Allergies:	lb/kg Heigh	nt: In/cm TBTe	est Result: Date:	
	ION INFORMATION			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILL
Litfulo	50 mg capsule	☐ Take 50 mg orally once daily with	or without food	28 days 84 days Refills:
Olumiant	2 mg tablet 4 mg tablet	2 mg PO once daily 4 mg PO once daily		Quantity: Refills:
Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly		Quantity: Refills:
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.		Quantity: 1 pack Refills: 0
Otezla	30 mg tablet	Maintenance Dose: 30 mg tablet	PO twice daily.	Quantity: Refills:
Remicade Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks		Quantity: # of 100 mg vial(s) Refills:
Rinvoq	15 mg	Take one 15 mg tablet PO daily		Quantity: Refills:
Siliq	Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)		Quantity: Refills:
Simponi	50 mg/0.5 mL SmartJect Autoinjector 50 mg/0.5 mL prefilled syringe	Psoriatic Arthritis Dose: Inject 50 mg SC once a month.		Quantity: Refills:
☐ Simponi ARIA	50 mg/4 mL in a single- dose vial	Psoriatic Arthritis Dosing: Induction Dose: 2 mg/kg IV infusion every 8 weeks thereafter Maintenance Dose: 2 mg/kg IV in	Quantity: # of 50 mg vial Refills:	
Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. Psoriasis Maintenance Dose: Inject 150 mg SC every 12 weeks.		Quantity: Refills:
Sotyktu	6 mg tablet	Take one 6 mg tablet PO once daily		Quantity: Refills:
Other	Strength:	□ Dose:		Quantity: Refills:
	in patient support programs ER SIGNATURE REC	STAMP SIGNATURE NOT ALLOWED QUIRED (STAMP SIGNATUR	Ancillary supplies and kits provided RE NOT ALLOWED)	as needed for administration
/ May Not Substitut Prescriber's S	ignature:	/ Do Not Substitute / No Substitution / DAW	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:
CA, MA, NC & PR:	Interchange is mandated unless Pres	scriber writes the words "No Substitution"	ATTN: New York and Iowa providers, please subm	nit electronic prescription

	Please Complete	e Patient , Prescriber a	and Patient Clini	cal Information	<u>h</u>
		Patient DOB:		Patient Phone: _	
		Prescr	iber Phone:		
Patient Clinical I					
Allergies:	lb/kg Height: _	In/cm TE	P Toet Pocult:	Date:	
DDESCDID	TION INFORMATION	III/OIII 11	3 1651 Result	Date	
MEDICATION	STRENGTH	DOS	E & DIRECTIONS		QUANTITY/REFILLS
MEDICATION	JIKENGIII	PsO Peds patients (6 to 17yo):			QUARITI IZ RELIES
☐ Stelara	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	< 60 kg: Inject 0.75 mg/kg: thereafter. 60 kg to 100 kg: Inject 45 m 12 weeks thereafter. > 100 kg: Inject 90 mg SC at thereafter. > 100 kg: Inject 90 mg SC at thereafter. > 60 kg: Inject 0.75 mg/kg 12 weeks thereafter. > 60 kg: Inject 45 mg SC at thereafter. > 100 kg with co-existent n weeks 0 and 4, then every 12 vests a later, followed by 45 mesh 12 weeks later, followed by 90 mesh 2 mesh 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 120 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 and 4, then every 100 kg (220lbs) with co-esc weeks 0 kg weeks 0	at weeks 0 and 4, then early seeks thereafter. Okg (220 lbs): Inject 45 mg every 12 weeks. Okg (220 lbs): Inject 90 mg every 12 weeks. Oand 4, then every 12 weeks. Oand 4, then every 12 weeks.	every 12 weeks hen every very 12 weeks 90 mg SC at mg SC initially and mg SC initially and	Quantity: Refills:
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	Psoriasis Dosing: Starting Dose: Inject SC tw. first induction dose 2 weeks la Induction Dose: Inject SC c 2-10). Final Induction Dose: Inject SC c Maintenance Dose: Inject SC pediatric Psoriasis Dosing: For patients weighing less that 40 mg at Week 0, followed For patients weighing 25-50 k 80 mg at Week 0, followed For patients weighing greater 160 mg (two 80 mg injectic weeks	to 80 mg injections on Dater. The second of	ry 2 weeks (weeks n (week 12). every 4 weeks. ks.	Quantity: 3 Pens/Syringes 2 Pens/Syringes 1 Pen/Syringe Refills:
☐ Taltz	80 mg Single Dose Autoinjector 80 mg Single Dose prefilled syringe	Psoriatic Arthritis Dosing: Starting Dose: Inject SC tw. Maintenance Dose: Inject S			Quantity: Refills:
Other	Strength:	Dose:			Quantity: Refills:
	in patient support programs ER SIGNATURE REQU	STAMP SIGNATURE NOT ALLOWED IRED (STAMP SIGNAT		, ,,	vided as needed for administration
DAW / May Not Sub Prescriber's Si	en" / Brand Medically Necessary / Do ostitute ignature: interchange is mandated unless Prescribe	Date:	May Substitute / Product Substitution Permissible Prescriber's Signat ATTN: New York a	ture:	Date:

	Please Comple	te Patient , Prescriber a	<u>nd Patient Clinical Informatio</u>	on .
Patient Name: _		Patient DOB:	Patient Phone:	
Prescriber Nam	e:	Prescrib	oer Phone:	
<u>Patient Clinical I</u>				
Allergies:			Test Result: Date:	
			Test Result: Date:	
	TION INFORMATION			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILLS
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One-Press patient-controlled injector	Starting Dose: Inject 100 mg Sodosing Maintenance Dose: Inject 100	C at weeks 0 and 4, then maintenance mg SC every 8 weeks	Quantity: Refills:
Xeljanz	☐ 5 mg tablet☐ 11 mg XR tablet	☐ Take one 5 mg tablet PO twice☐ Take one 11 mg PO once daily	e daily	Quantity: Refills:
☐ Yuflyma	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS 40 mg/0.4 mL PFS (with safety guard) 80 mg/0.8 mL PEN	one week after initial dose Inject 160 mg SC on Day 1 (sind days), 80 mg on Day 15, then 40 mInject 160 mg SC on Day 1 (sind loss)	eek wed by 40 mg every other week starting gle-dose or split over two consecutive	28 days 84 days Refills:
Other	Strength:	Dose:		Quantity: Refills:
	in patient support programs	STAMP SIGNATURE NOT ALLOWED		rovided as needed for administration
		UIRED (STAMP SIGNATU		
DAW / May Not Sub	ostitute	Do Not Substitute / No Substitution / Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:

Dermatology Enrollment Form Nursing Orders

Ple	ease Comp	olete Patient , Prescriber and Patient Clinical Informati	on
Patient Name:		Patient DOB:Patient Phone	•
Prescriber Name:		Prescriber Phone:	
<u>Patient Clinical Informatio</u>	<u>on:</u>		
Allergies:			
		ht: In/cm TB Test Result: Date	
		ON **ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DO	
MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: PIV PORT CVC/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) CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: Refills:
Hydration:	IV	Pre:	Hydration max infusion rate mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐Epinephrine **nursing requires**	□ IM □ SC	☐ 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911	Quantity: Refills:
Diphenhydramine Oral	РО	Premedication: ☐ 12.5 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: Refills:
Diphenhydramine 50 mg/mL vial **nursing required**	Slow IV	1 mg/kg (under 15 kg) 12.5 mg-50 mg (15-30 kg) 25 mg-50 mg (Over 30 kg) If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day) If severe allergic reaction: call 911	Quantity: Refills:
☐ Flush Orders:	Peripheral Access Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush (recommended if no post-hydration) ☐ Other:	Send quantity sufficient for medication days supply
Additional Medication:			
Patient is interested in patient supp PRESCRIBER SIGN		STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits EQUIRED (STAMP SIGNATURE NOT ALLOWED)	Drovided as needed for administration
DAW / May Not Substitute Prescriber's Signature:		y / Do Not Substitute / No Substitution / Date: Date: Bay Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa providers, ple	Date:

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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