

Inflammatory Bowel Disease Enrollment Form



Fax Referral To: 1-855-297-1270

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190

NCPDP: 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: Male Female
 Address: _____ City, State, ZIP Code: _____
 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: _____
 Email: _____ Last Four of SSN: _____ Primary Language: _____
 Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

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):

K50.90 Crohn's Disease, unspecified, without complications Date of Diagnosis __/__/__
 K51.90 Ulcerative colitis, unspecified, without complications Date of Diagnosis __/__/__
 Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in
 Treatment status: New to therapy Continuation of therapy; Date of last treatment __/__/__
 Is the patient on samples? No Yes; If yes, how many samples has patient received? _____
 TB Test Date __/__/__ Positive Negative Hepatitis status: _____
 Prior therapy, treatment dates, and reason(s) for discontinuation: _____

Nursing and Administration:

Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? Yes No
 Site of Care: Home Infusion* Coram Ambulatory Infusion Suite (AIS)* Prescriber's Office** Other Infusion Clinic

For Remicade/Remicade Biosimilars: First three doses to be given in controlled setting.

*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train.

**Prescriber's Office/Other Infusion Clinic: Drug only for facility administration

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Adalimumab-aacf (unbranded version of Idacio)	<input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg SC every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Amjevita (adalimumab-atto)	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on Day 1, 40 mg on Day 15, then 20 mg every other week starting Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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.

Inflammatory Bowel Disease Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___

Is the patient on samples? No Yes; If yes, how many samples has patient received? _____

TB Test Date ___/___/___ Positive Negative Hepatitis status: _____

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Avsola	100 mg vial	<input type="checkbox"/> Crohn's Disease (Adult and Pediatric ≥ 6 years old) <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Crohn's Disease (Adult) <u>Maintenance Dose:</u> Infuse IV at 5-10 mg/kg (Dose = _____ mg) every 8 weeks <input type="checkbox"/> Crohn's Disease (Pediatric ≥6 years old) <u>Maintenance Dose:</u> Infuse IV at 5 mg/kg (Dose = _____ mg) every 8 weeks <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) <u>Maintenance Dose:</u> Infuse IV at 5 mg/kg (Dose = _____ mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Adalimumab-adaz (unbranded version of Hyrimoz)	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS (with needle guard)	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Adalimumab-fkjp (unbranded version of Hudio)	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week starting Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<u>Induction Dose:</u> Inject SC 400 mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks	Quantity: 1 kit (6 prefilled syringes) Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg/1 mL prefilled syringe <input type="checkbox"/> 200 mg vial	<u>Maintenance Dose:</u> Inject SC 400 mg (2 injections) every 4 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Entyvio	300 mg vial	<u>Induction Dose:</u> <input type="checkbox"/> Week 0: Infusion 300 mg IV <input type="checkbox"/> Week 2: Infusion 300 mg IV <input type="checkbox"/> Week 6: Infusion 300 mg IV <u>Maintenance Dose:</u> <input type="checkbox"/> Inject 300 mg IV every 8 weeks	Quantity: _____ <input type="checkbox"/> 1 Vial <input type="checkbox"/> 2 Vials <input type="checkbox"/> 3 Vials Refills: 0
	108 mg/0.68 mL PEN	<input type="checkbox"/> Inject 108 mg SC every 2 weeks	Quantity: 1 Vial Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___

Is the patient on samples? No Yes; If yes, how many samples has patient received? _____

TB Test Date ___/___/___ Positive Negative Hepatitis status: _____

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

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<input type="checkbox"/> Hadlima	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Hulio	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on Day 1, 40 mg Day 15, then 20 mg every other week starting Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Humira	<input type="checkbox"/> 20 mg/0.2 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 80 mg/0.8 mL PFS <input type="checkbox"/> 80 mg/0.8 mL Pen	<input type="checkbox"/> Inject 20 mg SC every week <input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on day 1, 40 mg on day 15, then 20 mg every other week starting Day 29 <input type="checkbox"/> Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 20 mg every week starting day 29 <input type="checkbox"/> Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 40 mg every other week starting day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 8, 80 mg day 15, then 80 mg every other week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 8, 80 mg day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting on Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Hyrimoz	<input type="checkbox"/> 20 mg/0.2 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 80 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS (with needle guard) <input type="checkbox"/> 80 mg/0.8 mL PFS (with needle guard) <input type="checkbox"/> Pediatric Crohn's Starter Pack (<40kg) <input type="checkbox"/> Pediatric Crohn's Starter Pack (≥40kg) <input type="checkbox"/> Adult Crohn's and UC Starter Pack (carton of 3)	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week starting Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Idacio	<input type="checkbox"/> 40 mg/0.8mL PEN <input type="checkbox"/> 40 mg/0.8mL PFS	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in
 Treatment status: New to therapy Continuation of therapy; Date of last treatment __/__/____
 Is the patient on samples? No Yes; If yes, how many samples has patient received? _____
 TB Test Date __/__/__ Positive Negative Hepatitis status: _____
 Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Inflectra <input type="checkbox"/> Infliximab <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> Crohn's Disease (Adult and Pediatric ≥ 6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Crohn's Disease (Adult) <u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Crohn's Disease (Pediatric ≥6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) _____ Refills: _____
<input type="checkbox"/> Omvoh	<input type="checkbox"/> 300 mg/15 mL single dose vial <input type="checkbox"/> 2 x 100 mg/ mL PEN	<u>Induction Dose</u> <input type="checkbox"/> Week 0: Infuse 300 mg via IV infusion over at least 30 minutes <input type="checkbox"/> Week 4: Infuse 300 mg via IV infusion over at least 30 minutes <input type="checkbox"/> Week 8: Infuse 300 mg via IV infusion over at least 30 minutes <u>Maintenance Dose</u> <input type="checkbox"/> Inject 200 mg SC (given as two consecutive injections of 100 mg each) at Week 12 and every 4 weeks thereafter	Quantity: _____ <input type="checkbox"/> 1 Vial <input type="checkbox"/> 2 Vials <input type="checkbox"/> 3 Vials Refills: 0 Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Rinvoq	45 mg	<u>Induction Dose</u> : <input type="checkbox"/> Take 1 tablet once daily for 8 weeks <input type="checkbox"/> Take 1 tablet once daily for 12 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	<u>Maintenance Dose</u> : <input type="checkbox"/> Take 1 tablet once daily	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100 mg/mL in a single-dose prefilled SmartJect autoinjector <input type="checkbox"/> 100 mg/mL in a single-dose prefilled syringe	<input type="checkbox"/> <u>Induction Dose</u> : 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 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject SC 100 mg every 4 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 600 mg/10 mL (60 mg/mL) single dose vial <input type="checkbox"/> 360 mg/2.4 mL (150 mg/mL) single-dose prefilled cartridge with on-body injector	<u>Induction Dose</u> : <input type="checkbox"/> Week 0: Infuse 600 mg IV over at least one hour <input type="checkbox"/> Week 4: Infuse 600 mg IV over at least one hour <input type="checkbox"/> Week 8: Infuse 600 mg IV over at least one hour <u>Maintenance Dose</u> : <input type="checkbox"/> Inject 360 mg SC week 12 and every 8 weeks thereafter	Quantity: <u>1 Vial</u> Refills: <u>0</u> Quantity: <u>1 Vial</u> Refills: <u>0</u> Quantity: <u>1 Vial</u> Refills: <u>0</u> Quantity: 1 device with prefilled cartridge Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in

Treatment status: New to therapy Continuation of therapy; Date of last treatment __/__/__

Is the patient on samples? No Yes; If yes, how many samples has patient received? _____

TB Test Date __/__/__ Positive Negative Hepatitis status: _____

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Stelara	130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: _____. (This date is needed to determine shipment of Stelara SC maintenance dosage)	<u>Single IV Induction Dose:</u> <input type="checkbox"/> 55 kg or less 260 mg at Week 0: # of vials to be used 2 <input type="checkbox"/> more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3 <input type="checkbox"/> more than 85 kg 520 mg at Week 0: # of vials to be used 4	Quantity: _____ <input type="checkbox"/> 2 Vials <input type="checkbox"/> 3 Vials <input type="checkbox"/> 4 Vials Refills: 0
<input type="checkbox"/> Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	<input type="checkbox"/> 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Tysabri	NA	Please complete a MS TOUCH/Tysabri enrollment form and indicate CVS/specialty as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255)	Quantity: 0 Refills: 0
<input type="checkbox"/> Velsipity	2 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily	Quantity: _____ <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days Refills: _____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	<input type="checkbox"/> 10 mg twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily, depending on therapeutic response. Use the lowest effective dose to maintain response. Discontinue Xeljanz after 16 weeks of treatment with 10 mg twice daily if adequate therapeutic benefit is not achieved.	Quantity: _____ Refills: _____
<input type="checkbox"/> Yuflyma	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS (with safety guard) <input type="checkbox"/> 80 mg/0.8 mL PEN	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Zeposia	28-day Starter Kit: (Four 0.23 mg capsules, three 0.46 mg capsules, and one bottle containing twenty-one 0.92 mg capsules)	<input type="checkbox"/> Take 0.23 mg capsule orally once daily on days 1-4, then 0.46 mg capsule once daily on days 5-7, then 0.92 mg capsule once daily starting on day 8 and thereafter.	Quantity: 1 Kit (28-day supply) Refill: 0
<input type="checkbox"/> Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	<input type="checkbox"/> Take 0.23 mg capsule orally once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7.	Quantity: 7-day supply Refill: 0
<input type="checkbox"/> Zeposia	0.92 mg capsules	<input type="checkbox"/> Take 0.92 mg capsule orally once daily.	Quantity: _____ Refills: _____
<input type="checkbox"/> Zymfentra	<input type="checkbox"/> 120 mg/ mL PEN <input type="checkbox"/> 120 mg/ mL PFS (with needle guard)	<u>Maintenance dose only starting at week 10:</u> <input type="checkbox"/> 120 mg SC once every two weeks	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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Nursing Orders

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
 Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ kg lb Height: _____ cm in

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___

Is the patient on samples? No Yes; If yes, how many samples has patient received? _____

TB Test Date ___/___/___ Positive Negative Hepatitis status: _____

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION ****ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS****

MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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 & <input type="checkbox"/> Heparin 10 units/mL or <input type="checkbox"/> 100 units/mL 3-5 mL. PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5mL.	Quantity: _____ Refills: _____
Hydration: <input type="checkbox"/> NS <input type="checkbox"/> D5W	IV	Pre: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Concurrent: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Post: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Epinephrine <i>**nursing requires**</i>	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) <input type="checkbox"/> 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	Premedication: <input type="checkbox"/> 12.5 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine 50 mg/mL vial <i>**nursing required**</i>	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5 mg-50 mg (15-30 kg) <input type="checkbox"/> 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: _____
<input type="checkbox"/> Flush Orders:	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venous Access	<input type="checkbox"/> 10 mL NS post flush <input type="checkbox"/> 50 mL NS post flush (recommended if no post-hydration) <input type="checkbox"/> Other: _____	Send quantity sufficient for medication days supply
<input type="checkbox"/> Additional Medication: _____ _____	_____ _____	_____ _____	_____ _____

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: _____
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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

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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