Hemophilia Enrollment Form

CVS specialty®

Fax Referral To: 1-866-811-7450 **Phone:** 1-866-792-2731
Email Referral To: hemophiliaintaketeam@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: _____ 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. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. 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):

☐ D66 Hereditary factor VIII deficiency
☐ D67 Hereditary factor IX deficiency
☐ D68.0 Von Willebrand's disease
☐ D68.311 Acquired hemophilia
☐ D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
☐ D68.8 Other specified coagulation defects
☐ D68.9 Coagulation defect, unspecified
☐ D68.2 Hereditary deficiency of other clotting factors
☐ Other Code: _____ Description: _____

Patient Clinical Information:

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

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as 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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ AlphaNine ☐ Alprolix ☐ BeneFIX ☐ Coagadex ☐ Corifact ☐ Ceprotin ☐ Eloctate ☐ Feiba NF ☐ Hemofil-M ☐ Humate-P ☐ Idelvion ☐ Ixinity ☐ Jivi ☐ Koate-DVI ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Obizur ☐ Profilnine ☐ Rebinyn ☐ Recombinate ☐ Rixubis ☐ Thrombate III ☐ Tretten ☐ Vonvendi ☐ Wilate ☐ Xyntha	_____ IU/kg	☐ Prophylaxis: _____ ☐ On demand treatment: Infuse ____ units (+/- 10%) slow IV push every ____ hours / days (circle one) for a total of ____ doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ Minor Bleed: ___IU IV q ____ hr PRN ☐ Other: _____ ☐ Major Bleed: ___IU IV q ____ hr PRN ☐ Other: _____ ☐ Immune Tolerance: _____ Weight: _____ kg	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

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.

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Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Amicar	☐ Tablet 500 mg ☐ Tablet 1,000 mg ☐ Syrup 25%	☐ Other: _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ Altuviiio	☐ 50 IU/kg ☐ ____ IU/kg	☐ Prophylaxis: 50 IU/kg IV once weekly ☐ On demand treatment: 50 IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ Other: _____ Weight: _____ kg	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ Esperoct	☐ ____ IU/kg	☐ Prophylaxis: ___ IU/kg IV every ___ days or ___ times per week ☐ On demand treatment: ___ IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ Other: _____ Weight: _____ kg	Refills: ☐ 1 year ☐ Other: _____
☐ Hemlibra	☐ 12 mg/0.4 ml ☐ 30 mg/mL ☐ 60 mg/0.4 mL ☐ 105 mg/0.7 mL ☐ 150 mg/1 mL ☐ 300 mg/2 ml	☐ Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks ☐ Maintenance dose: ☐ 1.5 mg/kg subcutaneously every week ☐ 3 mg/kg subcutaneously every 2 weeks ☐ 6 mg/kg subcutaneously every 4 weeks Weight: _____ kg	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ NovoSeven RT	☐ ___ mcg/kg	Infuse _____ mcg/kg slow IV push every _____ hours, and/or _____ _____ Weight: _____ kg	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ SevenFact	☐ 1 mg ☐ 5 mg	For Mild/Moderate bleeds: ☐ 75 mcg/kg IV, repeat q 3 hours until hemostasis achieved or ☐ Initial dose of 225 mcg/kg IV. May infuse 75 mcg/kg IV q 3 hours prn if hemostasis not achieved within 9 hours. For Severe bleeds: ☐ 225 mcg/kg IV, followed if necessary 6 hours later with 75 mcg/kg IV every 2 hours. ☐ Other_____ Round to nearest whole vial. Weight: _____ kg	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Stimate	☐ 150 mcg	☐ Weight <50 kg: Single spray in one nostril ☐ Weight >50 kg: Single spray in each nostril (2 sprays total) ☐ Other: _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

Nursing Medications

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Normal Saline	Other: _____	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

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 u/mL or ☐ 100 units/mL 3-5mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: _____ Refills: _____
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
☐ Diphenhydramine 50 mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)	Quantity: _____ Refills: _____
☐ 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: _____
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____

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