Inflammatory Bowel Disease Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com
Coram National Call Center Fax : 1-866-843-3221

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
☐ Adalimumab-aacf (unbranded version of Idacio)	☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every other week ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Amjevita (adalimumab-atto)	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC on Day 1, 40 mg on Day 15, then 20 mg every other week starting Day 29 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ 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.

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Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Avsola	100 mg vial	☐ Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Adalimumab-adaz (unbranded version of Hyrimoz)	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 40 mg SC every other week ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Adalimumab-fkjp (unbranded version of Hulio)	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week starting Day 29 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: 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
☐ Cimzia	☐ 200 mg/1 mL prefilled syringe ☐ 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks	Quantity: _____ Refills: _____
☐ Entyvio	300 mg vial	Induction Dose: ☐ Week 0: Infusion 300 mg IV ☐ Week 2: Infusion 300 mg IV ☐ Week 6: Infusion 300 mg IV	Quantity: ☐ 1 Vial ☐ 2 Vials ☐ 3 Vials Refills: 0
		Maintenance Dose: ☐ Inject 300 mg IV every 8 weeks	Quantity: 1 Vial Refills: _____
	108 mg/0.68 mL PEN	☐ Inject 108 mg SC every 2 weeks	Quantity: 2 pens Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/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 every other week ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Hulio	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC on Day 1, 40 mg Day 15, then 20 mg every other week starting Day 29 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Humira	☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL PFS ☐ 80 mg/0.8 mL Pen	☐ Inject 20 mg SC every week ☐ Inject 20 mg SC every other week ☐ 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, 40 mg on day 15, then 20 mg every other week starting Day 29 ☐ 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 ☐ 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 ☐ 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 ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Hyrimoz	☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PEN ☐ 80 mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 80 mg/0.8 mL PFS (with needle guard) ☐ Pediatric Crohn's Starter Pack (<40kg) ☐ Pediatric Crohn's Starter Pack (≥40kg) ☐ Adult Crohn's and UC Starter Pack (carton of 3)	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week starting Day 29 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Idacio	☐ 40 mg/0.8mL PEN ☐ 40 mg/0.8mL PFS	☐ Inject 40 mg SC every other week ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity:____ Refills: _____

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

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Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ 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)	Single IV Induction Dose: ☐ 55 kg or less 260 mg at Week 0: # of vials to be used 2 ☐ more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3 ☐ more than 85 kg 520 mg at Week 0: # of vials to be used 4	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0
☐ Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	☐ 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
☐ 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
☐ Velsipity	2 mg	☐ Take 1 tablet by mouth once daily	Quantity: ☐ 30 days ☐ 90 days Refills: _____
☐ Xeljanz	☐ 5 mg ☐ 10 mg	☐ 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: _____
☐ 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	☐ Inject 40 mg SC every other week ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ 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)	☐ 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
☐ Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	☐ 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
☐ Zeposia	0.92 mg capsules	☐ Take 0.92 mg capsule orally once daily.	Quantity: _____ Refills: _____
☐ Zymfentra	☐ 120 mg/ mL PEN ☐ 120 mg/ mL PFS (with needle guard)	Maintenance dose only starting at week 10: ☐ 120 mg SC once every two weeks	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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Inflammatory Bowel Disease Enrollment Form
Nursing Orders

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Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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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: ☐ 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 3-5mL.	Quantity: _____ Refills: _____
Hydration: ☐ NS ☐ D5W	IV	Pre: ☐ 500 mL ☐ 1000 mL ☐Other: _____ Concurrent: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ Post: ☐500 mL ☐1000 mL ☐Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐ *Epinephrine* ***nursing requires***	☐ IM ☐ SC	☐ 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) ☐ 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) ☐ 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: _____
☐ Diphenhydramine Oral	PO	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 ☐ IM	☐ 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 support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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