

Hemophilia Enrollment Form



Fax Referral To: 1-877-232-5455
Address: 3375 Koapaka Street, Suite D105, Honolulu, HI 96819

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

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):

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

Patient Clinical Information:

Allergies: _____ Height: _____ in/cm Weight: _____ lb/kg
 Baseline Factor Level: _____

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
<input type="checkbox"/> Advate <input type="checkbox"/> Hemofil-M <input type="checkbox"/> Rebinyn <input type="checkbox"/> Adynovate <input type="checkbox"/> Humate-P <input type="checkbox"/> Recombinate <input type="checkbox"/> Afstyla <input type="checkbox"/> Idelvion <input type="checkbox"/> Rixubis <input type="checkbox"/> Alphanate <input type="checkbox"/> Ixinity <input type="checkbox"/> Thrombate III <input type="checkbox"/> AlphaNine <input type="checkbox"/> Jivi <input type="checkbox"/> Tretten <input type="checkbox"/> Alprolix <input type="checkbox"/> Koate-DVI <input type="checkbox"/> Vonvendi <input type="checkbox"/> BeneFIX <input type="checkbox"/> Kovaltry <input type="checkbox"/> Wilate <input type="checkbox"/> Corifact <input type="checkbox"/> Novoeight <input type="checkbox"/> Xyntha <input type="checkbox"/> Ceprotin <input type="checkbox"/> Nuwiq <input type="checkbox"/> Eloctate <input type="checkbox"/> Obizur <input type="checkbox"/> Feiba NF <input type="checkbox"/> Profilnine	_____ IU/kg	<input type="checkbox"/> Prophylaxis: _____ <input type="checkbox"/> 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. <input type="checkbox"/> Minor Bleed: _____ IU IV q _____ hr PRN <input type="checkbox"/> Other: _____ <input type="checkbox"/> Major Bleed: _____ IU IV q _____ hr PRN <input type="checkbox"/> Other: _____ <input type="checkbox"/> Immune Tolerance: _____ Weight: _____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> 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: _____
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Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.

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Please Complete Patient and Prescriber Information

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

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Alhemo	<input type="checkbox"/> 60 mg/1.5mL PEN <input type="checkbox"/> 150 mg/1.5mL PEN	<input type="checkbox"/> Loading Dose: Inject ____ subcutaneously once on Day 1, followed by ____ mg subcutaneously once daily until individualization of maintenance dose. <input type="checkbox"/> Maintenance dose: Inject ____ mg subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Amicar	<input type="checkbox"/> Tablet 500 mg <input type="checkbox"/> Tablet 1,000 mg <input type="checkbox"/> Syrup 25%	<input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Altuviio	<input type="checkbox"/> 50 IU/kg <input type="checkbox"/> ____ IU/kg	<input type="checkbox"/> Prophylaxis: 50 IU/kg IV once weekly <input type="checkbox"/> On demand treatment: 50 IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. <input type="checkbox"/> Other: _____ Weight: ____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Coagadex	<input type="checkbox"/> 250 IU <input type="checkbox"/> 500 IU	<input type="checkbox"/> Prophylaxis: ____ IU/kg IV twice weekly <input type="checkbox"/> On demand treatment: ____ IU/kg at the first sign of bleeding. Repeat at intervals of 24 hours until bleed stops. Contact your physician's office if bleeding does not resolve. <input type="checkbox"/> Other: _____ Weight: ____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Esperoct	<input type="checkbox"/> ____ IU/kg	<input type="checkbox"/> Prophylaxis: ____ IU/kg IV every ____ days or ____ times per week <input type="checkbox"/> On demand treatment: ____ IU/kg IV as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. <input type="checkbox"/> Other: _____ Weight: ____ kg	Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Hemlibra	<input type="checkbox"/> 12 mg/0.4 ml <input type="checkbox"/> 30 mg/mL <input type="checkbox"/> 60 mg/0.4 mL <input type="checkbox"/> 105 mg/0.7 mL <input type="checkbox"/> 150 mg/1 mL <input type="checkbox"/> 300 mg/2 ml	<input type="checkbox"/> Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks <input type="checkbox"/> Maintenance dose: <input type="checkbox"/> 1.5 mg/kg subcutaneously every week <input type="checkbox"/> 3 mg/kg subcutaneously every 2 weeks <input type="checkbox"/> 6 mg/kg subcutaneously every 4 weeks Weight: ____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> 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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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: _____
 Patient Address: _____
 Prescriber Name: _____ Prescriber Phone: _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Hympavzi	<input type="checkbox"/> 150 mg/mL PEN	<input type="checkbox"/> Initial dose: Inject 300 mg (two 150mg injections) subcutaneously once <input type="checkbox"/> Maintenance dose: Inject 150 mg subcutaneously every week	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> NovoSeven RT	<input type="checkbox"/> ____ mcg/kg	Infuse _____ mcg/kg slow IV push every _____ hours, and/or _____ Weight: _____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> SevenFact	<input type="checkbox"/> 1 mg <input type="checkbox"/> 5 mg	For Mild/Moderate bleeds: <input type="checkbox"/> 75 mcg/kg IV, repeat q 3 hours until hemostasis achieved or <input type="checkbox"/> 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: <input type="checkbox"/> 225 mcg/kg IV, followed if necessary 6 hours later with 75 mcg/kg IV every 2 hours. <input type="checkbox"/> Other: _____ Round to nearest whole vial. Weight: _____ kg	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Stimate	<input type="checkbox"/> 150 mcg	<input type="checkbox"/> Weight <50 kg: Single spray in one nostril <input type="checkbox"/> Weight >50 kg: Single spray in each nostril (2 sprays total) <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

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CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

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Nursing Medications

Please Complete Patient and Prescriber Information

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

5 PRESCRIPTION INFORMATION

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

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 u/mL or <input type="checkbox"/> 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: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 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	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)	Quantity: _____ Refills: _____
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3 mg/ 0.3 mL (greater than 30 kg/66lbs) <input type="checkbox"/> 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) <input type="checkbox"/> 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 5-15 minutes as needed For severe allergic reaction also call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____

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