

Lupus Enrollment Form



Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

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):

- M32.1 Systemic lupus erythematosus (SLE)
- M32.11 Endocarditis in systemic lupus erythematosus
- M32.12 Pericarditis in systemic lupus erythematosus
- M32.13 Lung involvement in systemic lupus erythematosus
- M32.14 Glomerular disease in systemic lupus erythematosus
- M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
- M32.19 Other organ or system involvement in systemic lupus erythematosus
- M32.8 Other forms of systemic lupus erythematosus
- M32.9 Systemic lupus erythematosus, unspecified
- Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm
Positive ANA or anti-dsDNA test? Yes No Date of test: ___/___/___

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

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Medication A-Z

Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ In/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Benlysta SC	<input type="checkbox"/> 200 mg/mL PEN (approved for use in patients 5 yrs. and older) <input type="checkbox"/> 200 mg/mL PFS (adult use only)	Patients 5 yrs and older with SLE ≥ 40 kg: <input type="checkbox"/> Inject 200mg SC once weekly Patients 5 yrs and older with SLE 15 kg to < 40 kg: <input type="checkbox"/> Inject 200mg SC once every 2 weeks Lupus Nephritis (LN) Dosing: <u>LN Adult Induction dose:</u> <input type="checkbox"/> Inject 400 mg (two 200 mg injections) once weekly for 4 doses <u>LN Adult Maintenance dose:</u> <input type="checkbox"/> Inject 200 mg once weekly	Quantity: 1 package (4 doses) Refills: _____
<input type="checkbox"/> Benlysta IV	<input type="checkbox"/> 120 mg/5 mL vial <input type="checkbox"/> 400 mg/20 mL vial	<input type="checkbox"/> Induction Dose: 10 mg/kg IV (Dose = ____mg) at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour. <input type="checkbox"/> Maintenance Dose: 10 mg/kg (Dose = ____mg) every 4 weeks Infuse IV over 1 hour	Quantity: ____ vials Refills: _____
<input type="checkbox"/> Saphnelo	300 mg/2 mL (150 mg/mL)	<input type="checkbox"/> 300 mg IV over a 30-minute period, every 4 weeks <input type="checkbox"/> Other: _____	Quantity: ____ vials Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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:** _____

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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