Lupus Enrollment Form

CVS specialty®

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____
☐ **Check box if patient is enrolled in manufacturer copay assistance** **If yes, please provide ID# _____**

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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Please Complete Patient and Prescriber Information

Patient Name: _____Patient DOB: _____Patient Phone:_____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____Weight: _____lb/kg Height:_____In/cm

5 PRESCRIPTION INFORMATION

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