

Remicade/Remicade Biosimilars Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: Male Female

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: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____ Relationship to minor: _____

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)

Insurance Company: _____ ID#: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10):

K50.00 Crohn's disease (CD) of the small intestine

K51.90 Ulcerative colitis (UC)

L40.0 Plaque psoriasis (PsO)

L40.50 Arthropathic psoriasis (PsA)

M06.9 Rheumatoid arthritis (RA)

M45.9 Ankylosing spondylitis (AS)

Other Code: _____ Description: _____

Allergies: _____ NKDA Weight: _____ lb kg Height: _____ in cm

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___ Needs by Date: _____

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

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

Remicade/Remicade Biosimilars Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ lb kg Height: _____ in cm

Prior therapy, treatment dates, and reason(s) for discontinuation _____

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___ Needs by Date: _____

5 PRESCRIPTION INFORMATION Ship to: Patient Office Other: _____

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Avsola <input type="checkbox"/> Inflectra <input type="checkbox"/> Infliximab <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> AS Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter	Quantity: _____ (# of vials) Refills: 0
		<input type="checkbox"/> AS Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks	Quantity: _____ (# of vials) Refills: _____
		<input type="checkbox"/> CD (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	Quantity: _____ (# of vials) Refills: 0
		<input type="checkbox"/> CD (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ (# of vials) Refills: _____
		<input type="checkbox"/> CD (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ (# of vials) Refills: _____
		<input type="checkbox"/> PsO/PsA Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter	Quantity: _____ (# of vials) Refills: 0
		<input type="checkbox"/> PsO/PsA Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ (# of vials) Refills: _____
		<input type="checkbox"/> RA Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter	Quantity: _____ (# of vials) Refills: 0
		<input type="checkbox"/> RA Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one)	Quantity: _____ (# of vials) Refills: _____
		<input type="checkbox"/> UC (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	Quantity: _____ (# of vials) Refills: 0
		<input type="checkbox"/> UC (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ (# of vials) Refills: _____
Other:	_____	_____	Quantity: _____ (# of vials) Refills: _____

Remicade/Remicade Biosimilars Enrollment Form Nursing Orders

Please Complete Patient, Prescriber and Patient Clinical Information

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

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: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC <input type="checkbox"/> CVL	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency <input type="checkbox"/> PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) <input type="checkbox"/> PORT/CVL - NS 10 mL & Heparin 100 units/mL 3-5 mL and 10 mL sterile saline to access port a cath <input type="checkbox"/> PICC - NS 10 mL & Heparin 10 units/mL 3-5 ML	Quantity: _____ Refills: _____
Hydration: <input type="checkbox"/> NS <input type="checkbox"/> D5W	IV	Pre: 500 mL 1000 mL Other: _____ Concurrent: 500 mL 1000 mL Other: _____ (Not to be infused using the same access as Ig) Post: 500 mL 1000 mL Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Epinephrine <i>**nursing required**</i>	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	Premedication: <input type="checkbox"/> 12.5 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 <i>**nursing required**</i>	<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 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg) PRN severe allergic reaction – Call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Flush Orders:	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venus Access	<input type="checkbox"/> 10 mL NS post flush <input type="checkbox"/> 50 mL NS post flush (recommended if no post-hydration) <input type="checkbox"/> Other: _____	Send quantity sufficient for medication days supply
<input type="checkbox"/> Additional Medication:	_____ _____	_____ _____	_____ _____

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.

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 Pharmacy, Inc.