Rheumatology IV 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):

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M45.9 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
☐ M45.A0 Ankylosing Spondylitis of Unspecified Sites in Spine
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ L40.59 Other Psoriatic Arthropathy
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ M08.90 Polyarticular Juvenile Idiopathic Arthritis (PJIA)
☐ M08.20 Systemic Juvenile Idiopathic Arthritis (SJIA)
☐ M31.6 Giant Cell Arteritis (GCA)
☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies:_____
Prior therapy, treatment dates, and reason(s) for discontinuation:
_____
Treatment status: ☐ New to therapy ☐ Continuation of therapy; date of last treatment ___/__/____ Needs by date: _____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

Nursing and Administration:

First dose administration of monoclonal antibodies (mABs) should be administered in a controlled setting (may vary depending upon medication specific policy).
For Remicade/Remicade Biosimilars, the first dose must be administered in a controlled setting.
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
*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

Rheumatology IV Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks. ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Avsola	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ Other:_____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Inflectra ☐ Infliximab	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ Other:_____	Quantity: _____ # of 100 mg vial(s) 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.

Rheumatology IV Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Orencia	250 mg vial	☐ Infuse ___ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Remicade ☐ Renflexis	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ Other:_____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Riabni ☐ Rituxan ☐ Ruxience	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single use vial	☐ Adult patients with Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter. ☐ Pediatric patients with polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis: 80 mg/m2 intravenous infusion over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter ☐ Other: _____	Quantity: _____ # of 50 mg vial 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.

Rheumatology IV Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Truxima	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Tyenne (tocilizumab-aazg)	☐ 80 mg/4 mL vial ☐ 200 mg/10 mL vial ☐ 400 mg/20 mL vial	☐ RA Induction Dose: Infuse 4 mg per kg (___ mg) IV every 4 weeks ☐ RA Maintenance Dose: Infuse 8 mg per kg (___ mg) IV every 4 weeks (doses exceeding 800 mg per infusion are not recommended) ☐ Giant Cell Arteritis Dose: Infuse 6 mg per kg (___ mg) IV every 4 weeks (doses exceeding 600 mg per infusion are not recommended) ☐ PJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 10 mg per kg (___ mg) IV every 4 weeks ☐ PJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (___ mg) IV every 4 weeks ☐ SJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 12 mg per kg (___ mg) IV every 2 weeks ☐ SJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (___ mg) IV every 2 weeks ☐ Other: _____	Quantity: ☐___(# of 80 mg vials) ☐___(# of 200 mg vials) ☐___(# of 400 mg vials) 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.

Rheumatology IV Enrollment Form
Nursing Orders

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

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) ☐ 1:2000, 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 to clear medication from tubing (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

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.