

Rheumatology IV 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):

- 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

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 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
<input type="checkbox"/> Actemra	<input type="checkbox"/> 80 mg/4 mL <input type="checkbox"/> 200 mg/10 mL <input type="checkbox"/> 400 mg/20 mL	<input type="checkbox"/> Induction Dose: Infuse 4 mg/kg every 4 weeks. <input type="checkbox"/> Maintenance Dose: Infuse 8 mg/kg every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Avsola	100 mg vial	<input type="checkbox"/> Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 6 weeks thereafter <input type="checkbox"/> Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) every 6 weeks <input type="checkbox"/> Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) every 8 weeks <input type="checkbox"/> Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____ mg) every 4, 6 or 8 weeks (circle one) <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Inflectra <input type="checkbox"/> Infliximab	100 mg vial	<input type="checkbox"/> Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 6 weeks thereafter <input type="checkbox"/> Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) every 6 weeks <input type="checkbox"/> Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____ mg) every 8 weeks <input type="checkbox"/> Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____ mg) every 4, 6 or 8 weeks (circle one) <input type="checkbox"/> 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.

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

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

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

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Please Complete Patient , Prescriber and Patient Clinical Information

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

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Nursing Orders

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 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: <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 units/mL or <input type="checkbox"/> 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: <input type="checkbox"/> NS <input type="checkbox"/> D5W	IV	Pre: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Concurrent: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Post: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Epinephrine <i>**nursing requires**</i>	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) <input type="checkbox"/> 1:2000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 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: _____
<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 mg-50 mg (15-30 kg) <input type="checkbox"/> 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: _____
<input type="checkbox"/> Flush Orders:	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venous Access	<input type="checkbox"/> 10 mL NS post flush <input type="checkbox"/> 50 mL NS post flush to clear medication from tubing (recommended if no post-hydration) <input type="checkbox"/> Other: _____	Send quantity sufficient for medication days supply
<input type="checkbox"/> Additional Medication: _____	_____ _____	_____ _____	_____ _____

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