

# Autoimmune IV Enrollment Form



Fax Referral To: 1-888-280-1191 OR 787-759-4161  
Phone: 1-888-280-1190 OR 787-759-4162  
Email Referral To: Customer.ServiceFax@CVSHealth.com  
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

## Six Simple Steps to Submitting a Referral

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

Patient Name: \_\_\_\_\_  
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. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*  
Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  Male  Female  
Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_  
Primary Language: \_\_\_\_\_

### 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 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
- K50.00 Crohn's Disease of Small Intestine Without Complications
- K50.10 Crohn's Disease of Large Intestine Without Complications
- K50.80 Crohn's Disease of Small & Large Intestine Without Complications
- K50.90 Crohn's Disease, Unspecified, Without Complications
- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- K51.50 Left sided colitis without complications
- K51.90 Ulcerative colitis, unspecified, without complications
- 710.0 Lupus
- Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm  
TB Test Result: \_\_\_\_\_ Date: \_\_\_\_\_ Hepatitis status: \_\_\_\_\_  
First time receiving IBD therapy?  Yes  No  
If no, previous product used: \_\_\_\_\_ Last dose given: \_\_\_\_\_ Next dose due: \_\_\_\_\_

# Medications A-I

## Autoimmune IV Enrollment Form

(Actemra, Avsola, Benlysta, Entyvio, Inflectra)

### Please Complete Patient and Prescriber information

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_

### 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"/> <u>Induction Dose:</u> Infuse 4 mg/kg every 4 weeks. <input type="checkbox"/> <u>Maintenance Dose:</u> Infuse 8 mg/kg every 4 weeks. <input type="checkbox"/> <u>Other:</u> _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Actemra	162 mg/0.9 mL prefilled syringe	<input type="checkbox"/> <u>For patients weighing &lt;100 kg:</u> Inject 162 mg SC every other week, followed by an increase to every week based on clinical response. <input type="checkbox"/> <u>For patients weighing ≥ 100 kg:</u> Inject 162 mg SC every week.	Quantity: _____ Refills: _____
<input type="checkbox"/> Avsola	100 mg vial	Rheumatoid Arthritis <u>Induction Dose in conjunction with methotrexate:</u> Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> <u>Rheumatoid Arthritis Maintenance Dose:</u> Infuse 3 mg/kg every 8 weeks. Psoriatic Arthritis <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> <u>Psoriatic Arthritis Maintenance Dose:</u> Infuse 5 mg/kg every 8 weeks. Ankylosing Spondylitis <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. <input type="checkbox"/> <u>Ankylosing Spondylitis Maintenance Dose:</u> Infuse 5 mg/kg every 6 weeks. <input type="checkbox"/> <u>Other:</u> _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 120 mg 5 mL vial <input type="checkbox"/> 400 mg 20 mL vial	<input type="checkbox"/> <u>Induction Dose:</u> 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.	Quantity: _____ vials Refills: _____
<input type="checkbox"/> Entyvio	<input type="checkbox"/> 300 mg in a single dose vial in individual carton	Recommended dosage in UC & CD: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Inflectra	100 mg vial	<input type="checkbox"/> <u>Induction Dose:</u> IV at 5 mg/kg (Dose = _____mg) at week 0, week 2, week 6 and every 8 weeks thereafter <input type="checkbox"/> <u>Maintenance Dose:</u> IV at 5 mg/kg (Dose = _____mg) every 8 weeks. <input type="checkbox"/> <u>Other:</u> _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: \_\_\_\_\_  
 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

### 6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_

X \_\_\_\_\_

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.

# Medications R-Z

## Autoimmune IV Enrollment Form

(Orencia, Remicade, Renflexis, Samponi ARIA, Stelara)

**Please Complete Patient and Prescriber Information**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_

### 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	100 mg vial	<input type="checkbox"/> Induction Dose: IV at 5 mg/kg (Dose = ___ mg) at week 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: IV at 5 mg/kg (Dose = ___ mg) every 8 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size
<input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> Induction Dose: IV at 5 mg/kg (Dose = ___ mg) at week 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: IV at 5 mg/kg (Dose = ___ mg) every 8 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size
<input type="checkbox"/> Rituxan	<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"/> Initial Dose: Inject SC 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at week 0, followed by 100 mg at week 2 and then 100 mg every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject SC 100 mg every 4 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130 mg/26 mL (5 mg/mL) IV single-dose vial	<b>Single IV Induction Dose:</b> <input type="checkbox"/> 55 kg or less 260 mg at week 0: # of vials to be used 2 <input type="checkbox"/> more than 55 kg to 85 kg 390 mg at week 0: # of vials to be used 3 <input type="checkbox"/> more than 85 kg 520 mg at week 0: # of vials to be used 4 <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 2 Vials <input type="checkbox"/> 3 Vials <input type="checkbox"/> 4 Vials Refills: 0

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Patient Signature: \_\_\_\_\_

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

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PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_

X \_\_\_\_\_

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# Nursing Medications Autoimmune IV Enrollment Form

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_  
 Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

**Complete Items below, required for Home Infusion:**

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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) PORT/PICC – NS 10 ml & Heparin 100 units/ml 3-5 ml, and/or 10 ml sterile saline to access port a cath	Quantity: _____ Refills: _____
<input type="checkbox"/> Epinephrine **nursing requires**	<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: _____
Premed Antihistamine: <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Dose will be rounded to the nearest vial size
<input type="checkbox"/> Flush Orders	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venous Access	<input type="checkbox"/> 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for maintenance <input type="checkbox"/> Heparin _____ units per mL flush with _____ units as final flush and as directed	Send quantity sufficient for medication days' supply
Additional Medication: _____	_____	_____	_____

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Patient Signature: \_\_\_\_\_  
 Patient is interested in patient support programs

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(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_ X \_\_\_\_\_

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