# Inflammatory Bowel Disease Enrollment Form

**CVS** specialty<sup>®</sup>

Fax Referral To: 1-855-297-1270PhorAddress: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

Phone: 1-888-280-1190

NCPDP: 4026325

DATIENT INFORM		ple Steps to Submitting a Referral	
	ATION (Complete or include de	emographic sheet)	
Patient Name:		DOB: Gender:    Male	Female
Address:		City, State, ZIP Code:	
		ded below) 🗌 Text (to cell # provided below) 🗌 Email (to email pro	ovided below)
Note: Carrier charges n	nay apply. If unable to contact via te	ext or email, Specialty Pharmacy will attempt to contact by phone.	
Primary Phone:		Alternate Phone:	
Email:		Last Four of SSN: Primary Language:	
Parent/Caregiver/Lega	al Guardian Name (Last, First):	Relationship to patient:	
PRESCRIBER INFO	ORMATION		
		State License #:	
	DEA #: Group or Hosp		
Address:		City State ZIP Code:	
Phone:	Fax Cor	City, State, ZIP Code: ntact Person:Contact's Phone:	
INSURANCE INFO	PMATION Please fax copy of pres	scription and insurance cards with this form, if available (front and b	
s the Patient Insured?		nrolled or eligible for Medicare/Medicaid? Yes No	Jucky
		_ Policy Holder's DOB: Relationship to Patient:	
Policy Holder's Name.	Talar	Policy Holder's DOB Relationship to Patient	
		phone: Policy ID: Group #:	
Policy ID:	·	Prescription Plan Telephone: 	
	· · · · ·		
	t is enrolled in manufacturer copay	assistance If yes, please provide ID#	
	CLINICAL INFORMATION		
Needs by Date:		Ship to: 🗌 Patient 🗌 Office 🗌 Other:	
Diagnosis (ICD-10):			
	ease, unspecified, without complica		
	olitis, unspecified, without complica		
_ Other Code:	Description		
Patient Clinical Inforn	nation:		
Allergies:		□ NKDA Weight:  kg □ lb Height:  cm □ in	
Treatment status: 🔲 🛚	New to therapy 🔝 Continuation of	therapy; Date of last treatment//	
Is the patient on sample	es? 🔲 No 🗌 Yes; If yes, how many	y samples has patient received?	
s the patient on sample	es? 🔲 No 🗌 Yes; If yes, how many	y samples has patient received?	
s the patient on sample TB Test Date//	es? 🔲 No 🗌 Yes; If yes, how many 🔲 Positive 🗌 Negative	y samples has patient received? Hepatitis status: uation:	
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DAW / May Not Substitute
Prescriber's Signature: \_\_\_\_\_

\_\_\_\_ 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.

**Prescriber's Signature:** 

Date:

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"

Date:

Patient Name:         Patient DOB:         Patient Phone:           Prescriber Name:         Prescriber Phone:		Please Complet	e Patient and I	Prescriber Information	
Prescriber Name: Prearriser Plane:			Patient DOB:		
Patient Clinical Information:         INKD         Weight:         Is of plant         Is of plant           Altergies:         Image: Imag	Patient Address:				
Allergies:	_		Pr	escriber Phone:	
Treatment status:    we we to therpy:    Continuation of therapy: Date of text treatment					· ·
Is the patient on samples?    No    Yes; Hyes, how many samples has patient received?	Allergies:		NKDA W	/eight: L kg L lb Height: L	] cm [_] in
TB Tost Date	Is the patient on s	amples? $\Box$ No $\Box$ Yes: If ves, how many	v samples has pat	ient received?	
Prior therapy, treatment dates, and reason(s) for discontinuation:       DOSE& DISECTIONS       QUANTITY/REFILU         MEDICATION       STRENCTH       DOSE& DISECTIONS       QUANTITY/REFILU         Adalinumab-       20 mg/0.4 mL PFS       Inject 20 mg SC overy veek       Quantity:         (urbranded       40 mg/0.8 mL PFS       Disect 20 mg SC overy veek       Quantity:         (urbranded       40 mg/0.8 mL PFS       Disect 20 mg SC overy veek       Quantity:         (adainumab-       20 mg/0.4 mL PFS       Disect 20 mg SC overy other wook starting Day 29       Prior there are any other wook starting Day 29         (adainumab-       20 mg/0.4 mL PFS       Disect 20 mg SC on Day 1 (byten in one day or split over, two consecutive days), 80 mg on Day 15, then 20 mg Control mod Starting Day 29       Quantity:         (adainumab-       40 mg/0.8 mL PFN       Disect 30 mg SC on Day 1 (byten in one day or split over, two week starting Day 29       Quantity:         (adainumab-       40 mg/0.8 mL PFN       Dischese (Aduit and Pediatric 2.6 years old)       Pd days         (adainumab-       100 mg vial       Dischese (Aduit Maintanance Dose: Infrase N at S mg/ng (Dose =mg) at weeks 0, 2, G and every 8 weeks       Quantity:       Pd days         (christa       Cimzia Starter Kit (6 prefilled syringe)       Maintenance Dose: Infrase V at S mg/ng (Dose =mg) at weeks 0, 2, G and every 8 weeks       Quantity: Litit       Pd or	TB Test Date/	/ Positive Negative	Hepatiti	is status:	
MEPCATION       STRENGTH       DOEE 2018210015       QUANTITY/REFIL         Adalimumab- fkip       20 mg/0.4 mL PFS       Inject 20 mg SC overy week       Out 100 mg VS, then 20 mg       Quantity:         Wrsion of Hubo       40 mg/0.8 mL PFS       Inject 20 mg SC overy week       Quantity:       B days         Adamse       40 mg/0.8 mL PFS       Inject 20 mg SC overy week       Quantity:       B days         Ampievita       20 mg/0.4 mL PFS       Inject 20 mg SC overy other week statisting Day 29       Quantity:       B days         Ampievita       20 mg/0.4 mL PFS       Inject 20 mg SC overy other week statisting Day 29       Quantity:       B days         Inject 30 mg SC overy other week statisting Day 29       Inject 30 mg SC overy other week statisting Day 29       Quantity:       B days         Inject 30 mg SC overy other week statisting Day 29       Inject 30 mg SC overy other week statisting Day 29       Quantity:       B days         Induction Dase       Induct 100 mg SC on Day 1 (given in one day or spilt over       B days       Rofilis:       P of the S Disase (Adult Maintance Dase;         Induction Dase       Induction Dase       Induction Dase;       Induction Dase;       Molitance Dase;       P of the S Disase (Adult Maintance Dase; <td>Prior therapy, trea</td> <td>tment dates, and reason(s) for discontin</td> <td></td> <td></td> <td></td>	Prior therapy, trea	tment dates, and reason(s) for discontin			
Adalimumab- fkip					
Adalmumab- fkjp       Do mg/0.4 mL PFS       Digiet 80 mg SC overy week       Quartity: 28 days         Marken Million       Ad mg/0.8 mL PEN       Digiet 80 mg SC on Day 1 (Johne in one day or split overy vor consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 28       Bet days         Marken Million       Do mg/0.4 mL PFS       Digiet 80 mg SC on Day 1 (Johne in one day or split overy other week starting Day 28       Digiet 80 mg SC on Day 1 (Johne in one day or split overy other week starting Day 28         Marken Million       Do mg/0.4 mL PFS       Digiet 80 mg SC on Day 1 (Johne in one day or split overy other week starting Day 28       Digiet 80 mg SC on Day 1 (Johne in one day or split over) every other week starting Day 29         Marken Million       Do mg/0.8 mL PEN       Digiet 80 mg SC on Day 1 (Johne in one day or split over) every other week starting Day 29       Reflits:         Marken Million       Do mg/0.8 mL PEN       Digiet 80 mg SC on Day 1 (Johne in one day or split over) every other week starting Day 29       Reflits:         Marken Million       Do mg vial       Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks Dictorative Colitis (Adult and Pediatric 26 years old)       Reflits:         Marken Millionance Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks Dictorative Colitis (Adult and Pediatric 26 years old)       Reflits:         Marken Dase (Linden Dase: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks       Reflits:       Quantity	MEDICATION	STRENGTH	_		QUANTITY/REFILLS
Adalimumab- fkip       0 mg/0.4 mL PFS implext 80 mg SC on Day 1, 40mg Day 15, then 20 mg implext 80 mg SC on Day 1, 40mg Day 15, then 20 mg implext 80 mg SC on Day 1, 40mg Day 15, then 20 mg implext 80 mg SC on Day 16, 40 mg server y implext 80 mg SC on Day 16, 40 mg SC on Day 16					Quantity
ft(p          40 mg/0.8 mL PFS          44 days         every other week starting Day 29          64 days         eversion of Hulio)          40 mg/0.8 mL PFN          10 mg/0.6 mL 40 mg 80 covery other week            Amjevita          20 mg/0.4 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS            10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS            10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            40 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            40 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            40 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            40 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            40 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            41 days          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          28 days            10 mg/0.8 mL PFS            10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS          10 mg/0.8 mL PFS					<u> </u>
(unbranded version of Hulio)        = 40 mg/0.8 mL PEN        = inject 60 mg SC on Day 15, then 40 mg every other week starting Day 29        = inject 20 mg /0.4 mL PFS        = inject 20 mg SC every other week        = inject 20 mg /0.4 mL PFS          = Amjevita (adalimumab- atro)        = 40 mg/0.8 mL PFS        = inject 20 mg SC every other week        = inject 20 mg SC every other week        = 28 days          = do mg/0.8 mL PFS        = inject 80 mg SC on Day 15, then 20 mg  = inject 80 mg SC on Day 16, 40 mg every other week starting Day 29        = inject 80 mg SC on Day 16, 40 mg every other week starting Day 29        = 28 days          = do mg/0.8 mL PFS        = inject 80 mg SC on Day 16, 40 mg every other week starting Day 29        = 24 days        = 28 days          = do mg/0.8 mL PEN        = inject 80 mg SC on Day 16, 40 mg every other week starting Day 29        = 28 days        = 28 days          = do mg/0.8 mL PEN        = inject 80 mg SC on Day 16, 40 mg every 8 weeks        = Corbor 5 Disease (AduIt Maintenance Dose:  = Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, is and every 8 weeks thereafter        = (Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, is and every 8 weeks        = dardevery 8 weeks          = Cimzia       Cimzia Starter Kit (6 prefilled syringes)        = Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, is and every 8 weeks        = dardevery 8 weeks        = dardevery 8 weeks        = dardevery 8 weeks        = dardevery 8 weeks        = dordevery 8 weeks        = dordevery 8 weeks					
version of Hulio)       two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29					-
characteristic       other week starting Day 29	-				
□ Amjevita (adaimumab- atto)       □ 20 mg/0.4 mL PFS □ lnject 60 mg SC on Dy 1, 40 mg on Day 15, then 20 mg every other week starting Day 29 □ lnject 60 mg SC on Dy 1, given in one day or split over two consecutive days), 80 mg on Day 15, 40 mg overy other week starting Day 29 □ lnject 60 mg SC on Day 15, 40 mg overy other week starting Day 29 □ lnject 60 mg SC on Day 15, 40 mg overy other week starting Day 29 □ lnject 60 mg SC on Day 15, 40 mg overy other week starting Day 29 □ lnject 60 mg SC on Day 15, 40 mg overy other week starting Day 29 □ lnject 60 mg SC on Day 15, 40 mg overy other week starting Day 29 □ lnject 70 mg view of the Seese (Adult and Pediatric 2 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Crohn's Disease (Pediatric 26 years old) Induction Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks □ loreartive Coltis (Adult and Pediatric 26 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ loreartive Coltis (Adult and Pediatric 26 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose integ SV and SV an					
□Anjevita.       □20 mg/0.4 mL PFS       □ mject 80 mg SC on Day 1, 40 mg on Day 15, then 20 mg       □ 28 days         (addimumab- atto)       □ 40 mg/0.8 mL PFS       □ mject 80 mg SC on Day 1 (given in one day or split over two consecutive days, 80 mg on Day 15, 40 mg every other weeks tarting Day 29       □ Crohn's Disease (Adult and Pediatric 2 6 years old)       □ Adult and Pediatric 2 6 years old)         □ Avsola       100 mg vial       □ Crohn's Disease (Adult Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Crohn's Disease (Adult Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks       Quantity:				-	
(adalimumab- atto)       40 mg/0.8 mL PFS       every other week starting Day 29       B4 days         (adalimumab- atto)       40 mg/0.8 mL PEN       Inject 100 mg Co. Days 1 (given in one day or split over two consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29       B4 days         (adalimumab- atto)       (adomg/0.8 mL PEN)       Inject 100 mg consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29       Refills:         (adomg/0.8 mL PEN)       (adomg/0.8 mL PEN)       Inject 100 mg consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29       Refills:         (adomg/0.8 mL PEN)       (adomg/0.8 mL PEN)       Inject 100 mg consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29       Refills:         (adomg/0.8 mL PEN)       (adomg/0.8 mL PEN)       Inject 100 mg consecutive days), 80 mg on Day 15, 40 mg every 8 weeks the consecutive days), 80 mg on Day 15, 40 mg every 8 weeks       Refills:         (adomg/0.8 mL PEN)       (adomg/0.8 mL PEN)       (adomg/0.8 mL PEN)       Refills:       Quantity: 1 kit (g prefilled syringes)         (adomg/0.8 mL PEN)       (addm/0.8 mg/mg 0.0 mg V)       (addm/0.8 mg/mg 0.0 mg V)       Refills: 0       Quantity: 1 Vial (addm/0.9 mg Vial       Quantity: 1 Vial (givent full consecs)					
atto)       40 mg/0.8 mL PEN       Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29       Refills:					
anony       anony <td< td=""><td>•</td><td></td><td></td><td>•</td><td>— -</td></td<>	•			•	— -
Image: series of the series	alloj				
Induction Doss:       Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter       Ouantity:					
Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter			Crohn's Disea	ase (Adult and Pediatric ≥ 6 years old)	
6 and every 8 weeks thereafter □ Crohrs Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks □ Crohrs Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Ulcerative Coltis (Adult and Pediatric ≥6 years old) Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter □ Ulcerative Coltis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter □ Ulcerative Coltis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Cimzia       Quantity: 1 kit (6 prefilled syringes) Induction Dose: Inject SC 400 mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks □ Cimzia       Quantity: 1 kit (6 prefilled syringes) Refills: 0 Quantity: Quantity: 1 kit (9 prefilled syringes) Refills: 0 Quantity: Quantity: 1 viai □ 200 mg viai       Quantity: 1 kit (9 prefilled syringes) Refills: 0 Quantity: Quantity: Quantity: 1 viai □ 2 viails 300 mg viai       Quantity: 1 kit (9 prefilled syringes) Refills: 0 Quantity: Quantity: 1 viai □ 2 viails 3 viails Refills: 0 Quantity: 1 viai □ 2 viails 3 viails Refills: 0 Maintenance Dose: □ Difect 300 mg IV □ Week 2: Infusion 300 mg IV □ Week 3: Infusion 300 mg IV □ Veery 8 weeks Prescriber's Signature:					
□ Avsola       100 mg vial       □ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks □ Crohn's Disease (Pediatric 26 years old)       Quantity:			-		
Avsola       100 mg vial       Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks Croin's Disease (Pediatric 26 years old)       Quantity:			-		
□ Avsola       100 mg vial       □ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: □ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) □ Induction Dose: □ Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Ulcerative Colitis (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 □ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: □ Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter □ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Induction Dose: Infuse IV at 6 mg/kg (Dose =mg) every 9 weeks □ Induction Dose: Infuse IV at 6 mg/kg (Dose =mg) every 9 weeks □ Cimzia □ Cimzia □ Cimzia □ Cimzia □ Cimzia □ Comg vial □ Cimzia □ Comg vial □ Cimzia □ Comg vial □ Cimzia □					
Avsola       100 mg vial       Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Ulcerative Colitis (Adult and Pediatric ≥ 6 years old)       Refills:					
□ Avsola       100 mg vial       Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Ulcerative Colitis (Adultand Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter       # of 100 mg vial(s) Refills:	_				Quantity:
Image: Induction Dose:       Induction Dose:       Induction Dose:       Infinition (X dutt and Pediatric ≥ 6 years old)       Refills:       Infinition (X dutt and Pediatric ≥ 6 years old)         Induction Dose:       Infinition (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (X dutt and Pediatric ≥ 6 years old)         Image: Variable (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (X dutt and Pediatric ≥ 6 years old)       Infinition (X dutt and Pediatric ≥ 6 years old)         Image: Variable (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (X dutt and Pediatric ≥ 6 years old)       Infinition (Y dutt and Pediatric ≥ 6 years old)         Image: Variable (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (Y dutt and Pediatric ≥ 6 years old)       Infinition (Y dutt and Pediatric ≥ 6 years old)         Image: Variable (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (Y dutt and Pediatric ≥ 6 years old)       Infinition (Y dutt and Pediatric ≥ 6 years old)         Image: Variable (X dutt and Pediatric ≥ 6 years old)       Maintenance Dose:       Infinition (Y dutt and Pediatric ≥ 6 years old)       Infinition (Y dutt and Pediatric ≥ 6 years old)         Induction Dose:       Induction Dose:       Induction Dose:       Infinition (Y dutt and Pediatric ≥ 6 years old)       Infinition (Y dutt and Pediatric ≥ 6 years old)         Induction Dorg vial       Veek (2: Infusion 300 mg IV	🗋 Avsola	100 mg vial			
Induction Dose:       Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter       Ulcerative Colitis (Adult and Pediatric ≥ 6 years old)         Maintenance Dose:       Infuse IV at 5 mg/kg       Quantity: 1 kit         (Dose =mg) every 8 weeks       Induction Dose:       Infuse IV at 5 mg/kg         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Infuse IV at 5 mg/kg         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Infuse IV at 5 mg/kg         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Infuse IV at 5 mg/kg         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Refills: 0         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Refills: 0         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Quantity:         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Quantity:         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       Maintenance Dose:       Quantity:         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       [Disterative Colitis (Adult and Pediatric ≥ 6 years old)       [Disterative Colitis (Adult and Pediatric ≥ 6 years old)         (Disterative Colitis (Adult and Pediatric ≥ 6 years old)       [Disterative					- · ·
6 and every 8 weeks thereafter       0         0       0			Induction Dose:		
Image: Second state of the second s			-		
Maintenance Dose:       Injust IV at 5 mg/kg (Dose =mg) every 8 weeks       Quantity: 1 kit (6 prefilled syringes)         Cimzia       Cimzia Starter Kit (6 prefilled syringes)       Induction Dose:       Inject SC 400 mg (2 injections) on day 1, and d weeks 2 and 4. If response occurs, follow with 400 mg every four weeks       Quantity: 1 kit (6 prefilled syringes)         Cimzia       200 mg/1 mL prefilled syringe 200 mg vial       Maintenance Dose:       Quantity:       Refills: 0         Induction Dose:       1 piect SC 400 mg       Quantity:       Quantity:       Quantity:       Quantity:         Induction Dose:       1 piect SC 400 mg (2 injections) every 4 weeks       Refills: 0       Quantity:       Quantity:         Induction Dose:       1 response occurs, follow with       Quantity:       Vails       Quantity:         So0 mg vial       1 Vial       Veek 0: Infusion 300 mg IV       2 Vials       Quantity:       1 Vial         Week 6:       Infusion 300 mg IV       Week 8:       Infusion 300 mg IV       Refills:       Quantity:       1 Vial         108 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Quantity: 1 Vial       Refills:       Refills:       Refills:       Prescriber's Signature:       Date:       Date:       Date:       Date:       Prescriber's Signature:       Date:       Date:       Date:       Date:					
Image: Comparison of Compar					
Induction Dose:       Inject SC 400 mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks       Quantity: 1 kit (6 prefilled syringes) Refills: 0         Image: Cimzia       200 mg/1 mL prefilled syringe       Maintenance Dose:       Inject SC 400 mg       Quantity: 1 kit (6 prefilled syringes) Refills: 0         Image: Cimzia       200 mg/1 mL prefilled syringe       Maintenance Dose:       Inject SC 400 mg       Quantity:         Image: Cimzia       200 mg vial       Maintenance Dose:       Inject SC 400 mg       Quantity:         Image: Cimzia       200 mg vial       Maintenance Dose:       Quantity:       Quantity:         Image: Cimzia       300 mg vial       Induction Dose:       Quantity:       Quantity: 1 Vial         Image: Cimzia       300 mg vial       Induction Dose:       Quantity:       1 Vial         Image: Cimzia       300 mg vial       Induction Dose:       Quantity:       1 Vial         Image: Cimzia       300 mg vial       Induction 300 mg IV       Image: Quantity:       1 Vial         Image: Cimzia       108 mg/0.68 mL PEN       Inject 300 mg IV every 8 weeks       Quantity: 2 pens Refills:       Quantity: 2 pens Refills:         Image: Cimzia       108 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Quantity: 2 pens Refills:       Prescriber's Signa					
Cimzia       Cimzia Starter Kit (6 prefilled syringes)       at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks       (6 prefilled syringes)         Cimzia       200 mg/1 mL prefilled syringe       Maintenance Dose: Inject SC 400 mg 200 mg vial       Quantity:				· •, · ,	Quantity: 1 kit
400 mg every four weeks       Refills: 0         Cimzia       200 mg/1 mL prefilled syringe       Maintenance Dose: Inject SC 400 mg       Quantity:	🗌 Cimzia	Cimzia Starter Kit (6 prefilled svringes)			• •
Cimzia       200 mg/1 mL prefilled syringe       Maintenance Dose: Inject SC 400 mg       Quantity:					
Image: Severy 4 weeks       Refults:		200 mg/1 mL prefilled syringe			Quantity:
Induction Dose:       Induction Dose:       Induction Dose:         Week 0: Infusion 300 mg IV       Infusion 300 mg IV       Infusion 300 mg IV         Week 2: Infusion 300 mg IV       Infusion 300 mg IV       Infusion 300 mg IV         Week 6: Infusion 300 mg IV       Infusion 300 mg IV       Infusion 300 mg IV         Week 6: Infusion 300 mg IV       Infusion 300 mg IV       Infusion 300 mg IV         Infusion 300 mg IV       Infusion 300 mg IV       Infusion 300 mg IV         Infusion 300 mg IV       Infusion 300 mg IV       Refills: 0         Maintenance Dose:       Quantity: 1 Vial         Inject 300 mg IV every 8 weeks       Refills:         108 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Quantity: 2 pens         "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /       May Substitute / Product Selection Permitted /         Substitute       Prescriber's Signature:       Date:       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		200 mg vial	(2 injections) eve	ery 4 weeks	
Image: Service of the service of th			Induction Dose:		<u> </u>
300 mg vial       Week 2: Infusion 300 mg IV       Image: Constraint of the second sec			Week 0: Infus	sion 300 mg IV	
Image: Construct of the second sec		300 mg vial		0	
Maintenance Dose:       Quantity: 1 Vial         Inject 300 mg IV every 8 weeks       Refills:         108 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Quantity: 2 pens         BPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)       Quantity: 2 pens         "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /       May Substitute / Product Selection Permitted /         Substitute       Prescriber's Signature:Date:       Date:Date:Date: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	Entyvio		Week 6: Infus	sion 300 mg IV	
108 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Quantity: 2 pens Refills: <b>5</b> PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)       May Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitution Permissible       May Substitute / Product Selection Permitted / Substitution Permissible         Prescriber's Signature:			Maintenance Do	se:	
ID8 mg/0.68 mL PEN       Inject 108 mg SC every 2 weeks       Refills:         6       PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)       May Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitution Permissible         **Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute       May Substitute / Product Selection Permitted / Substitution Permissible         Prescriber's Signature:Date:       Date:Date:Date:Date:       Date:Date: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					Refills:
		108 ma/0.68 mL PEN	Inject 108 mg	ISC every 2 weeks	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /       May Substitute / Product Selection Permitted /         DAW / May Not Substitute       Prescriber's Signature:					Refills:
DAW / May Not Substitute       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		IIGNATURE REQUIRED (STAMP SIGN	IATURE NOT AL	LOWED)	
Prescriber's Signature:       Date:       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			No Substitution /	-	
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription			Date:		Date
· · · · · · · · · · · · · · · · · · ·					
	CA, MA, NC & PR: Int	•			

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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		hatory Bowel Disease Enrollment Form	
		se Complete Patient and Prescriber Information	
Patient Name:		Patient DOB:Patient Phone:	
Patient Address:	·		
Prescriber Name	e:	Prescriber Phone:	
<b>Patient Clinica</b>	l Information:		
Allergies:		NKDA Weight: 🗌 kg 🗌 lb Height: 🗍	cm 🗌 in
Treatment statu	us: 🗌 New to therapy	NKDA Weight: kg  lb Height:	
Is the patient or	n samples? 🔲 No 🗌 Yes; If y	yes, how many samples has patient received?	
TB Test Date _	_// 🗌 Positive 🗌 Ne	egative Hepatitis status:	
Prior therapy, ti	reatment dates, and reason(s	) for discontinuation:	
5 PRESCRIPTI	ON INFORMATION		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
		🗌 Inject 40 mg SC every other week	
		Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Quantity:
	40 mg/0.4 mL PEN	days), 80 mg on Day 15,	28 days
🗌 Hadlima	40 mg/0.8 mL PEN	then 40 mg every other week starting Day 29	84 days
	40 mg/0.4 mL PFS	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Refills:
	40 mg/0.8 mL PFS	days), 80 mg on Day 15, then	
		40 mg every other week starting Day 29	
		Inject 20 mg SC every other week	
		Inject 40 mg SC every other week	Quantity:
	20 mg/0.4 mL PFS	Inject 80 mg SC on Day 1, 40 mg Day 15, then 20 mg every other week	28 days
🗌 Hulio	40 mg/0.8 mL PFS	starting Day 29	🗌 84 days
	40 mg/0.8 mL PEN	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Refills:
		days), 80 mg on Day 15, then	
		40 mg every other week starting Day 29	
		Inject 20 mg SC every week	
		Inject 20 mg SC every other week	
		Inject 40 mg SC every week	
		Inject 40 mg SC every other week	
		Inject 80 mg SC every other week	
		Inject 80 mg SC on day 1, 40 mg on day 15, then 20 mg every other week	
		starting Day 29	
	20 mg/0.2 mL PFS	Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 20 mg	Quantity:
_	40 mg/0.4 mL PFS	every week starting day 29	🗌 28 days
🔄 Humira	40 mg/0.4 mL Pen	Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 40 mg	🗌 84 days
	80 mg/0.8 mL PFS	every other week starting day 29	Refills:
	🗌 80 mg/0.8 mL Pen	Inject 160 mg SC on Day 1 (single-dose or split over two consecutive	
		days), 80 mg on Day 8, 80 mg day 15, then	
		80 mg every other week starting on Day 29	
		Inject 160 mg SC on Day 1 (single-dose or split over two consecutive	
		days), 80 mg on Day 8, 80 mg day 15, then	
		40 mg every week starting on Day 29	
		Inject 160 mg SC on Day 1 (single-dose or split over two consecutive	
		days), 80 mg on Day 15, then 40 mg every other week starting on Day 29	
		Inject 40 mg SC every other week	
	40 mg/0.4 mL PEN	Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week	Quantity:
🗌 Hyrimoz	40 mg/0.4 mL PFS	starting Day 29	28 days
	(with needle guard)	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	84 days
		days), 80 mg on Day 15, then 40 mg every other week starting Day 29	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 /		May Substitute / Product Selection Permitted /	
DAW / May Not Substitute		Substitution Permissible	
Prescriber's Signature:	Date:	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.

#### CI. .

		omplete Patient and Prescriber Information	
Patient Name		Patient DOB:Patient Phone:Patient Phone:Pat	
Patient Clinical			
		NKDA Weight: 🗌 kg 🗌 lb Height: 🗍	om 🗆 in
Treatment statu	s: New to therapy	NKDA Weight: L kg L lb Height: L c	
Is the natient on	samples? $\Box$ No $\Box$ Yes: If yes he	ow many samples has patient received?	
	$/$ _/ Positive $\Box$ Negative		
		iscontinuation:	
MEDICATION		DOSE & DIRECTIONS	<b>QUANTITY/REFIL</b>
MEDIOATION	GINERATI	Crohn's Disease (Adult and Pediatric $\geq$ 6 years old) Induction Dose:	QOANTITIKEIN
		Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8	
🗌 Inflectra		weeks thereafter	
		Crohn's Disease (Adult)	
		<u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose =mg) every	
🗌 Infliximab		8 weeks	Quantity:
		☐ Crohn's Disease (Pediatric ≥6 years old)	# of 100 mg vial(s)
	100 mg vial	<u>Maintenance Dose</u> : Infuse IV at 5 mg/k (Dose =mg) every	Refills:
🗌 Remicade		8 weeks	
—		$\Box$ Ulcerative Colitis (Adult and Pediatric $\geq$ 6 years old) <u>Induction</u>	
		Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and	
Renflexis		every 8 weeks thereafter	
		$\Box$ Ulcerative Colitis (Adult and Pediatric $\geq$ 6 years old) <u>Maintenance</u>	
		Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks	
		Induction Dose	Quantity:
	300 mg/15 mL single dose	Week 0: Infuse 300 mg via IV infusion over at least 30 minutes	🗌 1 Vial
		Week 4: Infuse 300 mg via IV infusion over at least 30 minutes	2 Vials
		Week 8: Infuse 300 mg via IV infusion over at least 30 minutes	3 Vials
			Refills: 0
	vial	Induction Dose	Quantity:
		Week 0: Infuse 900 mg via IV infusion over at least 30 minutes	3 Vials
Omvoh		Week 4: Infuse 900 mg via IV infusion over at least 30 minutes	6 Vials
		Week 8: Infuse 900 mg via IV infusion over at least 30 minutes	9 Vials Refills: 0
		Maintanana Daga	Remus: U
	2 x 100 mg/mL PEN	Maintenance Dose	
	2 x 100 mg/mL PFS	each) at Week 12 and every 4 weeks thereafter	Quantity:
	1 x 100 mg/mL + 1 x 200 mg/		28 days
	2 mL PEN	Maintenance Dose	☐ 84 days
	1 x 100 mg/mL + 1 x 200 mg/	Inject 300 mg SC (given as two consecutive injections of 100 mg	Refills:
	2 mLPFS	each) at Week 12 and every 4 weeks thereafter	
	130 mg/26 mL (5 mg/mL) IV		Quantity:
	single-dose vial		2 Vials
	Date Infusion was completed or	Single IV Induction Dose:	3 Vials
🗌 Pyzchiva	scheduled: (This date is	55  kg or less  260  mg at Week  0: #  of vials to be used  2	4 Vials
	needed to determine shipment	more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3	Refills: 0
	of Stelara SC maintenance	more than 85 kg 520 mg at Week 0: # of vials to be used 4	
	dosage)		
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
🗌 Pyzchiva	SC dose in a single-dose	every 8 weeks thereafter.	Refills:
	prefilled syringe	🗌 Inject 90 mg SC every 8 weeks	
		Induction Dose:	Quantity:
🗌 Rinvoq	45 mg	Take 1 tablet once daily for 8 weeks	Refills:
1		Take 1 tablet once daily for 12 weeks	

## 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

CA MA NC & DP: Interchance is mandated unless Prescriber writes the words "No Substitution"	ATTN: New York and Iowa providers please submit electronic prescription
Prescriber's Signature: Date:	Prescriber's Signature: Date:
DAW / May Not Substitute	Substitution Permissible
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /

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# **Inflammatory Bowel Disease Enrollment Form**

		y BOWEL DISEase Lin Ollinein Torm	
Patient Name:		nplete Patient and Prescriber Information Patient DOB:Patient Phone:	
_			
		Prescriber Phone:	
Patient Clinical			
Allergies:		NKDA Weight: kg lb Height: ntinuation of therapy; Date of last treatment//	
		many samples has patient received?	
		continuation:	
5 PRESCRIPT MEDICATION	ION INFORMATION STRENGTH	DOSE & DIRECTIONS	OUANTITY /DEFULLS
MEDICATION			QUANTITY/REFILLS
🗌 Rinvoq	│	Maintenance Dose:	Quantity:
		Take 1 tablet once daily	Refills:
	130 mg/26 mL (5 mg/mL) IV single-dose vial	Single IV Induction Dose:	Quantity:
	Date Infusion was completed or	55 kg or less 260 mg at Week 0: # of vials to be used 2	3 Vials
🗌 Selarsdi	scheduled: (This date is	🗌 more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be	4 Vials
	needed to determine shipment of	used 3	Refills: 0
	Stelara SC maintenance dosage)	more than 85 kg 520 mg at Week 0: # of vials to be used 4	Nonas. O
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
Selarsdi	SC dose in a single-dose prefilled	every 8 weeks thereafter.	Refills:
	syringe	Inject 90 mg SC every 8 weeks	
		Inject 40mg SC every other week	Quantity:
Simlandi	40 mg/0.4 mL PEN	Inject 160mg SC on Day 1 (given in one day or split over two	28 days
(adalimumab-	40 mg/0.4 mL PFS	consecutive days), 80 mg on Day 15, then 40mg SC every other	84 days
ryvk)	🗌 80 mg/0.8 mL PEN	week starting Day 29	Refills:
	100 mg/mL in a single-dose	Induction Dose: Inject SC 200 mg initially (given as 2	
🗌 Simponi	prefilled SmartJect autoinjector	subcutaneous injections of 100 mg each) at Week 0, followed by	Quantity:
	100 mg/mL in a single-dose	100 mg at Week 2 and then 100 mg every 4 weeks	Refills:
	prefilled syringe	<u>Maintenance Dose</u> : Inject SC 100 mg every 4 weeks	
		Intravenous CD Induction Dose:	Quantity: <u>1 Vial</u> Refills: <u>0</u>
		Week 0: Infuse 600 mg IV over at least one hour	Quantity: <u>1 Vial</u> Refills: <u>0</u>
		Week 4: Infuse 600 mg IV over at least one hour	Quantity: <u>1 Vial</u> Refills: <u>0</u>
	600 mg/10 mL	Week 8: Infuse 600 mg IV over at least one hour	
	(60 mg/mL) single dose vial	Intravenous UC Induction Dose:	
		Week 0: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
Skyrizi		Week 4: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
	180 mg/1.2 mL (150 mg/mL)	Week 8: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
	single-dose prefilled cartridge	Maintenance UC or CD Dose (Option 1):	Quantity: 1 device with
	with on-body injector	☐ Inject 180 mg SC every 8 weeks	prefilled cartridge
	360 mg/2.4 mL	Maintenance UC or CD Dose (Option 2):	premieu our muge
	(150 mg/mL) single-dose prefilled	☐ Inject 360 mg SC week 12 and every 8 weeks thereafter	Refills:
	cartridge with on-body injector	Inject 360 mg SC every 8 weeks	
	130 mg/26 mL (5 mg/mL) IV		Quantity:
	single-dose vial	Single IV Induction Dose:	2 Vials
	Date Infusion was completed or	55 kg or less 260 mg at Week 0: # of vials to be used 2	3 Vials
Stelara	scheduled: (This date is	more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be	
	needed to determine shipment of	used 3 $\square$ means then 25 km 500 means the Weak 0: the finite to be used 4	Refills: 0
	Stelara SC maintenance dosage)	more than 85 kg 520 mg at Week 0: # of vials to be used 4	
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
🗌 Stelara	SC dose in a single-dose prefilled	every 8 weeks thereafter.	Refills:
	syringe	🗌 Inject 90 mg SC every 8 weeks	

## **6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

CA, MA, NC & PR: Interchange is mandated unless Prescribe	r writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa provide	rs, please submit electronic prescription
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
DAW / May Not Substitute		Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /		May Substitute / Product Selection Permitted /	

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.

# Inflammatory Bowel Disease Enrollment Form

		plete Patient and Prescriber Information		
Patient Name:				
	::			
Prescriber Name: Prescriber Phone:				
	al Information:			
		🗌 NKDA 🛛 Weight: 🗌 kg 🗌 lb Height:	$\Box$ cm $\Box$ in	
Treatment stat	us: New to therapy	NKDA Weight: kg 🗌 lb Height: ntinuation of therapy; Date of last treatment//		
Is the patient o	n samples? 🗌 No 🗍 Yes; If yes, how	many samples has patient received?		
	_// Positive Negative	Hepatitis status:		
Prior therapy, t	reatment dates, and reason(s) for disc	continuation:		
5 PRESCRIP	TION INFORMATION			
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS	
	130 mg/26 mL (5 mg/mL) IV single-	Single IV Induction Dose:	Quantity:	
	dose vial	55  kg or less 260 mg at Week 0: # of vials to be used 2	2 Vials	
🗌 Steqeyma	Date Infusion was completed or	$\square$ more than 55 kg to 85 kg 390 mg at Week 0: # of vials to	🔲 3 Vials	
	scheduled: (This date is	be used 3	4 Vials	
	needed to determine shipment of	$\square$ more than 85 kg 520 mg at Week 0: # of vials to be used 4	Refills: 0	
	Stelara SC maintenance dosage)			
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose,	Quantity:	
🗌 Steqeyma	SC dose in a single-dose prefilled	then every 8 weeks thereafter.	Refills:	
	syringe	Inject 90 mg SC every 8 weeks		
	200 mg/20 mL	Intravenous UC or CD Induction Dose:	Quantity: 1 Vial Refills: 0	
	(10 mg/mL) single-dose vial	Week 0: Infuse 200 mg IV over at least one hour	Quantity: 1 Vial Refills: 0	
		Week 4: Infuse 200 mg IV over at least one hour Week 8: Infuse 200 mg IV over at least one hour	Quantity: 1 Vial Refills: 0	
		Subcutaneous CD Induction Dose:	çaanay: i via ricinic. c	
	Induction Pack for Crohn's	Week 0: Inject 400 mg SC at Week 0	Quantity: 1 Pack Refills: 0	
	Disease (2 x 200 mg/2 mL Pens)	Week 4: Inject 400 mg SC at Week 4	Quantity: 1 Pack Refills: 0	
	Disease (2 × 200 mg/2 me Pens)	Week 8: Inject 400 mg SC at Week 8	Quantity: 1 Pack Refills: 0	
Tremfya		Maintenance UC or CD Dose (Option 1):		
		Week 16: Inject 100 mg SC at week 16 and every 8 weeks		
	200 mg/2 mL PEN	thereafter	Quantity: 56 DS Refills: 0	
	200 mg/2 mL PFS	Inject 100 mg SC every 8 weeks	Quantity: 56 DS Refills:	
	100 mg/mL single-dose One-			
	Press patient-controlled injector	Maintenance UC or CD Dose (Option 2):	Quantity: 28 DS Refills: 0	
	100 mg/mL PEN     100 mg/mL PFS	Week 12: Inject 200 mg SC week 12 and every 4 weeks		
			Quantity: 28 DS Refills:	
		Inject 200 mg SC every 4 weeks	Quantity: 84 DS Refills:	
		Please complete a MS TOUCH/Tysabri enrollment form and		
🗌 Tysabri	NA	indicate CVS/specialty as your preferred pharmacy provider.	Quantity: 0	
	NA	(For questions, please contact TOUCH Prescribing Program	Refills: 0	
		at 1-800-456-2255)		
	130 mg/26 mL (5 mg/mL) IV single-	Single IV Induction Dose:	Quantity:	
_	dose vial	55  kg or less 260 mg at Week 0: # of vials to be used 2	2 Vials	
	Date Infusion was completed or	$\square$ more than 55 kg to 85 kg 390 mg at Week 0: # of vials to	3 Vials	
Ustekinumab	scheduled: (This date is	be used 3	4 Vials	
	needed to determine shipment of	more than 85 kg 520 mg at Week 0: # of vials to be used 4	Refills: 0	
	Stelara SC maintenance dosage)			
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose,	Quantity:	
Ustekinumab	SC dose in a single-dose prefilled	then every 8 weeks thereafter.	Refills:	
	syringe	Inject 90 mg SC every 8 weeks	Quantity: Refills:	
Other	Strength:	Dose:	Quantity Relits	

# **5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

"Dispense As Written" / Brand Medically Necessary DAW / May Not Substitute <b>Prescriber's Signature:</b>	/ Do Not Substitute / No Substitution /Date:	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:
CA, MA, NC & PR: Interchange is mandated unless Pre	scriber writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa providers,	please submit electronic prescription

CA, MA, NC & PR: Interchange is mandated unless	Prescriber writes the words "No Substitution"	ATTN: New York and Iowa

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			Enrollment Form	
	Please Complete	Patient and Press		
Patient Name:		Patient DOB:	Patient Phone:	
Patient Address: _				
Prescriber Name:		Prescrib	er Phone:	
Patient Clinical				
Allergies:		NKDA Weight:	kg 🗌 lb Height: C	m 🗌 in
	s: 🗌 New to therapy 👘 🗌 Continuat	ion of therapy; Date of	last treatment//	
	samples? 🔲 No 🗌 Yes; If yes, how many			
			us:	
	atment dates, and reason(s) for discontinu	ation:		
	ION INFORMATION			1
MEDICATION	STRENGTH	D	DSE & DIRECTIONS	QUANTITY/REFILLS
				Quantity:
U Velsipity	2 mg	Take 1 tablet by m	outh once daily	30 days
		-	90 days	
			in at least 0 weaks fallowed by E at 10	Refills:
			for at least 8 weeks; followed by 5 or 10 ading on therapeutic response. Use the	Quantity:
🗌 Xeljanz	🔲 5 mg	<b>o i</b> 1	to maintain response.	Refills:
	🗌 10 mg		fter 16 weeks of treatment with 10 mg	Nonus
			e therapeutic benefit is not achieved.	
	130 mg/26 mL (5 mg/mL) IV single-dose		· · ·	Quantity:
	vial	Single IV Induction Do		2 Vials
Yesintek	Date Infusion was completed or		ng at Week 0: # of vials to be used 2 o 85 kg 390 mg at Week 0: # of vials to	3 Vials
resinter	scheduled: (This date is needed	be used 3	0 85 kg 390 mg at week 0. # of viais to	4 Vials
	to determine shipment of Stelara SC	_	20 mg at Week 0: # of vials to be used 4	Refills: 0
	maintenance dosage)		-	
	90 mg/mL		weeks after the initial IV induction dose,	Quantity:
Yesintek	SC dose in a single-dose prefilled syringe	then every 8 weeks th		Refills:
	_	Inject 90 mg SC ev		Quantity
	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS	Inject 40 mg SC ev	легу отпег weeк on Day 1 (given in one day or split over	Quantity: 28 days
🗌 Yuflyma	$\square$ 40 mg/0.4 mL PFS (with safety guard)		), 80 mg on Day 15, then 40 mg every	$\square$ 84 days
	$\square$ 80 mg/0.8 mL PEN	other week starting D		Refills:
	28-day Starter Kit: (Four 0.23 mg		sule orally once daily on days 1-4, then	
	capsules, three 0.46 mg capsules, and		e daily on days 5-7, then 0.92 mg	Quantity: 1 Kit (28-day
🗌 Zeposia	one bottle containing twenty-one 0.92 mg	• •	arting on day 8 and thereafter.	supply)
	capsules)			Refill: 0
	7-Day Starter Pack	Take 0.23 mg cap	sule orally once daily on days 1-4,	Quantity: 7-day supply
🗌 Zeposia	(4 capsules of 0.23 mg and 3 capsules of	followed by 0.46 mg o	capsule once daily on days 5-7.	Refill: 0
	0.46 mg)			
Zeposia	0.92 mg capsules	Take 0.92 mg can	sule orally once daily.	Quantity:
				Refills:
				Quantity:
Zymfentra	120 mg/ mL PEN	Maintenance dose on	/ V	28 days
	120 mg/ mL PFS (with needle guard)	120 mg SC once ev	very two weeks	B4 days
				Refills: Quantity:
Other	Strength:	Dose:		Refills:
				Nonao

# 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do No DAW / May Not Substitute <b>Prescriber's Signature:</b>	ot Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber v	writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa providers,	please submit electronic prescription

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# Inflammatory Bowel Disease Enrollment Form Nursing Orders

	Dies	Complete Detientend Dressriber Information	
Datiant Nama:	Plea	se Complete Patient and Prescriber InformationPatient DOB:Patient Phone:Patient Phone:	
Patient Address:			
Prescriber Name:		Prescriber Phone:	
Patient Clinical Informatio	<u>n:</u>	NKDA Weight: 🗌 kg 🗌 lb Height:	
Allergies:	to thoropy	INKDA Weight: Isg I b Height: Continuation of therapy; Date of last treatment//	
		yes, how many samples has patient received?	
TB Test Date / /		egative Hepatitis status:	
		) for discontinuation:	
<b>PRESCRIPTION INFO</b>		**ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE A	T HOME/CORAM AIS**
MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
		Catheter Care/Flush – Only on drug admin days – SASH or PRN to	
		maintain IV access and patency	
Catheter:		PIV: NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days)	Quantity:
	IV	CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL	Refills:
		3-5 mL.	
		PORT: 10 mL sterile saline to access PORT w/ huber needle	
		NS 10 mL & Heparin 100 units/mL 3-5mL.	
			Hydration max infusion
Hydration:		Pre: 500 mL 1000 mL 0ther:	rate mL/hr
	IV	Concurrent: 500 mL 1000 mL 0ther:	(Adult max rate
		Post:   500 mL  1000 mL  Other:	250 mL/hr unless
			otherwise indicated)
		1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs)	
Epinephrine	🗌 ІМ	1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs)	Quantity:
**nursing requires**	□sc	1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg)	Refills:
		Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	
		Premedication:	
Diphenhydramine	PO	12.5 mg/kg (0-30 kg)	Quantity:
Oral	FU	25 mg	Refills:
		50 mg (Over 30 kg)	
		1 mg/kg (under 15 kg)	
Diphenhydramine		12.5 mg-50 mg (15-30 kg)	
50 mg/mL vial	Slow IV	25 mg-50 mg (Over 30 kg)	Quantity:
**nursing required**		If mild/moderate reaction: may repeat in 3-5 minutes as needed	Refills:
	_	(Adult max dose: 100 mg/day)	
		If severe allergic reaction: call 911	
	Peripheral		
	Access	10 mL NS post flush	Send quantity
Flush Orders:	Central	50 mL NS post flush	sufficient
	Venous	(recommended if no post-hydration)	for medication days
	Access	Other:	supply
Additional			
Medication:			
Detiont is interacted in patient our	ort programa	STAMD SIGNATURE NOT ALLOWED Application Application Applications	arovidad as pooded for administration

#### **OPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

Prescriber's Signature:	Date:	Prescriber's Signature:	_Date:
	<b>B</b>		
DAW / May Not Substitute		Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute	May Substitute / Product Selection Permitted /		

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_\_\_\_\_\_ ATTN: New York and Iowa providers, please submit electronic prescription

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