

# Lupus Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

NCPDP: 4026325

## 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):

M32.1 Systemic lupus erythematosus (SLE)

M32.11 Endocarditis in systemic lupus erythematosus

M32.12 Pericarditis in systemic lupus erythematosus

M32.13 Lung involvement in systemic lupus erythematosus

M32.14 Glomerular disease in systemic lupus erythematosus

M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus

M32.19 Other organ or system involvement in systemic lupus erythematosus

M32.8 Other forms of systemic lupus erythematosus

M32.9 Systemic lupus erythematosus, unspecified

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg

Height: \_\_\_\_\_ in/cm

Positive ANA or anti-dsDNA test?  Yes  No

Date of test: \_\_/\_\_/\_\_\_\_

#### Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary?  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Health

Injection training not necessary. Date training occurred: \_\_\_\_\_

Reason:  MD office training patient  Pt already independent  Referred by MD to alternate trainer

# Lupus Enrollment Form

## Medication A-Z

### Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

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

**Patient Clinical Information:**

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ In/cm

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Benlysta SC	<input type="checkbox"/> 200 mg/mL PEN (approved for use in patients 5 yrs. and older)  <input type="checkbox"/> 200 mg/mL PFS (adult use only)	<b>Patients 5 yrs and older with SLE ≥ 40 kg:</b> <input type="checkbox"/> Inject 200mg SC once weekly <b>Patients 5 yrs and older with SLE 15 kg to &lt; 40 kg:</b> <input type="checkbox"/> Inject 200mg SC once every 2 weeks <b>Lupus Nephritis (LN) Dosing:</b> <u>LN Adult Induction dose:</u> <input type="checkbox"/> Inject 400 mg (two 200 mg injections) once weekly for 4 doses <u>LN Adult Maintenance dose:</u> <input type="checkbox"/> Inject 200 mg once weekly	Quantity: 1 package (4 doses) Refills: _____
<input type="checkbox"/> Benlysta IV	<input type="checkbox"/> 120 mg/5 mL vial <input type="checkbox"/> 400 mg/20 mL vial	<input type="checkbox"/> Induction Dose: 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.  <input type="checkbox"/> Maintenance Dose: 10 mg/kg (Dose = ____mg) every 4 weeks Infuse IV over 1 hour	Quantity: ____ vials Refills: _____
<input type="checkbox"/> Saphnelo	300 mg/2 mL (150 mg/mL)	<input type="checkbox"/> 300 mg IV over a 30-minute period, every 4 weeks <input type="checkbox"/> Other: _____	Quantity: ____ vials Refills: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Quantity: _____ 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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