

Lysosomal Storage Disorders Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

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: _____ Group or Hospital: _____
State License #: _____ NPI #: _____ DEA #: _____
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 Coram Ambulatory Infusion Suite Other: _____

Diagnosis (ICD-10):

Date of Diagnosis: _____
 E74.02 Pompe Disease: Infantile Onset Late Onset
 E75.21 Fabry Disease: Exhibiting clinical signs/symptoms? Yes No
 E75.22 Gaucher Disease: Type 1 Type 2 Type 3
CYP2D6 Genotype: Ultra Rapid Extensive Intermediate Poor
 E75.24 Niemann-Pick disease, acid sphingomyelinase deficiency (ASMD)
 E75.5 Other Lipid Storage Disorders
 E76.0 Mucopolysaccharidosis I (MPS I)
 E76.1 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
 E76.219 Mucopolysaccharidosis IVA (MPS IVA, Moroquio A Syndrome)
 E76.29 Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy Syndrome)
 Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

Nursing:

Specialty Pharmacy to coordinate Nursing? Yes No Port? Yes No
Site of Care: Physician Office Infusion Clinic Outpatient Hospital Home Infusion Other: _____

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Please Complete Patient and Prescriber Information

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

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Aldurazyme	2.9 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Cerdelga	84 mg capsule	Take 1 capsule _____ time(s) per day.	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Cerezyme	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Elaprase	6 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Eleyso	200 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Fabrazyme	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 35 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Kanuma	20 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Lumizyme	50 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Miglustat	100 mg capsule	Take 1 capsule three times per day	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Naglazyme	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
<input type="checkbox"/> Nexviazyme	100 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Vpriv	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Vimizim	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
<input type="checkbox"/> Xenpozyme	20mg Vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Escalation Required (Please attach Rx for escalation dose)	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months

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: _____
Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.	

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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Nursing Medications

Please Complete Patient and Prescriber Information

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

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
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
<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
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg)
<input type="checkbox"/> Diphenhydramine 50mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____

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