Asthma Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

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)

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 ☐ Other: _____

Diagnosis (ICD-10):

☐ J45.4 Moderate Persistent Asthma ☐ J45.5 Severe Persistent Asthma
☐ D72.119 Hypereosinophilic syndrome (HES) ☐ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
☐ J33.0 Polyp of the nasal cavity ☐ J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus
☐ J33.9 Nasal Polyp, unspecified (indication for dupilumab and omalizumab) ☐ J82.83 Eosinophilic asthma
☐ K20.0 Eosinophilic esophagitis (EoE)
☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm IgE Level: _____
Eosinophil count: _____ Cells/μL Date of test: __/__/___ Number of exacerbations in the last 12 months: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cinqair (reslizumab)	100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes ☐ Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte auto guard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30 mL syringe (one per vial shipped) • 50 mL 0.9% NaCl • 2 – 10 mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials ☐ 28-day supply ☐ 84-day supply ☐ ___-day supply Refills: ☐ 1 year ☐ Other: _____

☐ 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 Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Dupixent (dupilumab)	**PFS** ☐ 100 mg/0.67 mL pre-filled syringe ☐ 200 mg/1.14 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe **PEN*** ☐ 200 mg/1.14 mL pre-filled pen ☐ 300 mg/2 mL pre-filled pen *Comes in cartons of 2	**Asthma: Pediatric 15 to <30 kg:** ☐ Inject 100 mg SC (one injection) every other week ☐ Inject 300 mg SC (one injection) every four weeks **Asthma: Pediatric ≥30 kg:** ☐ Inject 200 mg SC (one injection) every other week **Asthma: Adult Initial Dose:** ☐ Inject 400 mg SC (2-200 mg injections in different injection sites) initially then 200 mg SC every other week ☐ Inject 600 mg SC (2-300 mg injections in different injection sites) initially then 300 mg SC every other week **Asthma: Adult Maintenance Dose:** ☐ Inject 200 mg (one injection) SC every other week ☐ Inject 300 mg (one injection) SC every other week **Chronic Sinusitis with Nasal Polyposis in Patients ≥ 12 y/o** ☐ Inject 300 mg (one injection) SC every other week **Eosinophilic Esophagitis (EoE)** ☐ Inject 300 mg SC every week	Quantity: _____ Refills: _____
☐ Fasenra (benralizumab)	**PFS** ☐ 10mg/0.5ml pre-filled syringe ☐ 30 mg/mL pre-filled syringe **Auto-injector** ☐ 30 mg/mL Pen	**Severe Asthma** ☐ Administer 10 mg/0.5 ml by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter ☐ Administer 30 mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter ☐ Other: Administer _____ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)** ☐ Inject 30 mg SC every 4 weeks Note: Pre-filled syringe is administered by healthcare provider. Autoinjector can be caregiver or self-administered if patient is 12 years of age and weighs more than 35kg.	Quantity: ☐ 1 PFS/Pen ☐ 3 PFS/Pen Refills: ☐ 1 year ☐ Other: _____

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5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Nucala (mepolizumab)	**Vial** ☐ 100 mg vial **PEN** ☐ Auto-injector 100 mg/mL auto-injector **PFS** ☐ 100 mg/mL pre-filled syringe ☐ 40 mg/0.4 mL pre-filled syringe	**Severe Asthma** ☐ **Adults & Adolescents 12 years and older**: Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen ☐ **Pediatric (6-11 years old):** Inject 40 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen **Chronic Rhinosinusitis with Nasal Polyps:** ☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen **Eosinophilic Granulomatosis with Polyagniitis (EGPA)** ☐ Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen **Hypereosinophilic Syndrome (HES)** ☐ Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Nucala dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution 1 mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection	Quantity: ☐ 28-day supply ☐ 84-day supply ☐ ___-day supply Refills: ☐ 1 year ☐ Other: _____
☐ Tezspire (Tezepelumab)	**PFS** ☐ 210 mg/1.91 mL (110 mg/mL) pre-filled syringe **PEN** ☐ 210 mg/1.91 mL (110 mg/mL) pre-filled pen	Inject 210mg subcutaneously every 4 weeks	Quantity: 1 Refills: 1 Year

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Xolair (omalizumab)	**Vial** ☐ 150 mg vial kit **PFS** ☐ 75 mg/0.5 mL pre-filled syringe ☐ 150 mg/1 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe **Auto-injector** ☐ 75 mg/0.5 mL ☐ 150 mg/mL ☐ 300 mg/2 mL	**Every 4 weeks dosing:** ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks **For Xolair Vials only:** ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Xolair dispensed • Alcohol swabs • Flexible bandages 1" x 3" • 3 mL Luer Lock injection syringe • NDL 18G x 1½" Safety Glide needle for reconstitution NDL 25G x ⅝" Safety Glide needle for subcutaneous injection	Quantity: ☐ 28-day supply ☐ 84-day supply ☐ ___-day supply Refills: ☐ 1 year ☐ Other: _____

I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

Nursing Medications

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	Other: _____	Other: _____	Quantity:_____ Refills:_____
☐ EpiPen	Other: _____	Use as directed.	Quantity: 1 Refills: _____
☐ EpiPen Jr.	Other: _____	Use as directed.	Quantity: 1 Refills: _____

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