Autoimmune IV Enrollment Form

CVS specialty®

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

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
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks. ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Actemra	162 mg/0.9 mL prefilled syringe	☐ For patients weighing <100 kg: Inject 162 mg SC every other week, followed by an increase to every week based on clinical response. ☐ For patients weighing ≥ 100 kg: Inject 162 mg SC every week.	Quantity: _____ Refills: _____
☐ Avsola	100 mg vial	Rheumatoid Arthritis Induction Dose in conjunction with methotrexate: Infuse IV at 3 mg/kg (Dose = ____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. ☐ Ankylosing Spondylitis Maintenance Dose: Infuse 5 mg/kg every 6 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
☐ Benlysta	☐ 120 mg 5 mL vial ☐ 400 mg 20 mL vial	☐ 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.	Quantity: ___ vials Refills: _____
☐ Entyvio	☐ 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: _____
☐ Inflectra	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____mg) at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ___mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size

☐ 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)

X_____

DISPENSE AS WRITTEN (Date)

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
☐ Orencia	250 mg vial	☐ Infuse ___ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Remicade	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____mg) at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ____mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size
☐ Renflexis	100 mg vial	☐ Induction Dose: IV at 5 mg/kg (Dose = ____mg) at week 0, week 2, week 6 and every 8 weeks thereafter. ☐ Maintenance Dose: IV at 5 mg/kg (Dose = ___mg) every 8 weeks. ☐ Other: _____	Quantity: _____ # of 100 mg vial Refills: _____ Dose will be rounded to the nearest vial size
☐ Rituxan	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single use vial	☐ 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 ☐ Maintenance Dose: Inject SC 100 mg every 4 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara	☐ 130 mg/26 mL (5 mg/mL) IV single-dose vial	Single IV Induction Dose: ☐ 55 kg or less 260 mg at week 0: # of vials to be used 2 ☐ more than 55 kg to 85 kg 390 mg at week 0: # of vials to be used 3 ☐ more than 85 kg 520 mg at week 0: # of vials to be used 4 ☐ Other: _____	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0

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DISPENSE AS WRITTEN (Date)

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Nursing Medications
Autoimmune IV Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name:_____ Patient DOB:_____

Prescriber Name:_____ Prescriber Phone:_____

5 PRESCRIPTION INFORMATION

Complete Items below, required for Home Infusion:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ 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: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ 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: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Dose will be rounded to the nearest vial size
☐ Flush Orders	☐ Peripheral Access ☐ Central Venus Access	☐ 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for maintenance ☐ 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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DISPENSE AS WRITTEN (Date)

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