Autoimmune IV 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): ☐ Date of Diagnosis __/__/__

- ☐ K50.00 Crohn's Disease of Small Intestine Without Complications
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ L40.50 Arthropathic Psoriasis, Unspecified
- ☐ L40.54 Juvenile Psoriatic Arthritis (JPsA)
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M08.00 Juvenile Idiopathic Arthritis (JIA)
- ☐ M08.90 Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- ☐ M08.20 Systemic Juvenile Idiopathic Arthritis (SJIA)
- ☐ M31.6 Giant Cell Arteritis (GCA)
- ☐ M32.1 Systemic lupus erythematosus (SLE)
- ☐ M32.14 Glomerular disease in systemic lupus erythematosus
- ☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
- ☐ M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
- ☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
TB Test Date __/__/__ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

Nursing and Administration:

First dose administration of monoclonal antibodies (mABs) should be administered in a controlled setting (may vary depending upon medication specific policy).
For Remicade/Remicade Biosimilars, the first dose must be administered in a controlled setting.
Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ Home Infusion* ☐ Coram Ambulatory Infusion Suite (AIS)* ☐ Prescriber's Office** ☐ Other Infusion Clinic
*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train.
**Prescriber's Office/Other Infusion Clinic: Drug only for facility administration

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Patient Address:_____
Prescriber Name: _____ Prescriber Phone: _____

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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	Quantity: _____ Refills: _____
☐ Avsola	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (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 ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ 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) every 8 weeks	Quantity: _____ # of 100 mg vial(s) 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	☐ Induction Dose: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 300 mg infused IV over 30 minutes every 8 weeks	Quantity: _____ 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 / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____	**Prescriber's Signature: _____Date: _____**

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☐ Inflectra ☐ Infliximab	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (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 ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ 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) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Omvoh	300 mg/15 mL single dose vial	**Induction Dose** ☐ Week 0: Infuse 300 mg via IV infusion over at least 30 minutes ☐ Week 4: Infuse 300 mg via IV infusion over at least 30 minutes ☐ Week 8: Infuse 300 mg via IV infusion over at least 30 minutes	Quantity: Refills: 0 ☐ 1 Vial ☐ 2 Vials ☐ 3 Vials
☐ Orencia	250 mg vial	☐ Infuse ___ mg at weeks 0, 2 and 4, then every 4 weeks thereafter	Quantity: ___ Refills: ___
☐ Remicade ☐ Renflexis	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 6 weeks ☐ Crohn's Disease (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 ☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ 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) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: ___ Refills: ___

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☐ Riabni ☐ Rituxan ☐ Ruxience	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks	Quantity: _____ Refills: _____
☐ Saphnelo	300 mg/2 mL (150 mg/mL)	☐ 300 mg IV over a 30-minute period, every 4 weeks	Quantity: ____ vials Refills: _____
☐ Simponi ARIA	50 mg/4 mL single dose vial	**Adult RA, PsA, AS Induction Dose** ☐ Week 0: Infuse 2 mg/kg IV (Dose=____mg) over 30 minutes ☐ Week 4: Infuse 2 mg/kg IV (Dose=____mg) over 30 minutes	Quantity: ____ vials Refills: 0 Quantity: ____ vials Refills: 0
		Adult RA, PsA, AS Maintenance Dose ☐ Infuse 2 mg/kg IV (Dose=_____mg) over 30 minutes every 8 weeks	Quantity: ____ vials Refills: _____
		Peds JIA or PsA (≥2 years old) Induction Dose ☐ Week 0: Infuse 80 mg/m^2 IV (Dose=_____mg) over 30 minutes ☐ Week 4: Infuse 80 mg/m^2 IV (Dose=_____mg) over 30 minutes	Quantity: ____ vials Refills: 0 Quantity: ____ vials Refills: 0
		Peds JIA or PsA (≥2 years old) Maintenance Dose ☐ Infuse 80 mg/m^2 IV (Dose=_____mg) over 30 minutes every 8 weeks	Quantity: ____ vials Refills: _____
☐ Skyrizi	☐ 600 mg/10 mL (60 mg/mL) single dose vial	**Induction Dose:** ☐ Week 0: Infuse 600 mg IV over at least one hour ☐ Week 4: Infuse 600 mg IV over at least one hour ☐ Week 8: Infuse 600 mg IV over at least one hour	Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0
		☐ Week 0: Infuse 1,200 mg IV over at least two hours ☐ Week 4: Infuse 1,200 mg IV over at least two hours ☐ Week 8: Infuse 1,200 mg IV over at least two hours	Quantity: 2 vials Refills: 0 Quantity: 2 vials Refills: 0 Quantity: 2 vials Refills: 0
☐ 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	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0

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Prescriber Name: _____ Prescriber Phone: _____

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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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☐ Tremfya	☐ 200 mg/20 mL (10 mg/mL) single-dose vial	**Intravenous UC or CD Induction Dose:** ☐ Week 0: Infuse 200 mg IV over at least one hour ☐ 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 Quantity: 1 Vial Refills: 0 Quantity: 1 Vial Refills: 0
☐ Truxima	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Tyenne (tocilizumab-aazg)	☐ 80 mg/4 mL vial ☐ 200 mg/10 mL vial ☐ 400 mg/20 mL vial	☐ RA Induction Dose: Infuse 4 mg per kg (___ mg) IV every 4 weeks ☐ RA Maintenance Dose: Infuse 8 mg per kg (___ mg) IV every 4 weeks (doses exceeding 800 mg per infusion are not recommended) ☐ Giant Cell Arteritis Dose: Infuse 6 mg per kg (___ mg) IV every 4 weeks (doses exceeding 600 mg per infusion are not recommended) ☐ PJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 10 mg per kg (___ mg) IV every 4 weeks ☐ PJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (___ mg) IV every 4 weeks ☐ SJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 12 mg per kg (___ mg) IV every 2 weeks ☐ SJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (___ mg) IV every 2 weeks ☐ Other: _____	Quantity: ☐ ___(# of 80 mg vials) ☐ ___(# of 200 mg vials) ☐ ___(# of 400 mg vials) Refills:_____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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Nursing Orders

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TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
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5 PRESCRIPTION INFORMATION

****ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS****

MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: ☐ PIV ☐ PORT ☐ CVC/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) CVC/PICC: NS 10 mL & ☐ Heparin 10 units/mL or ☐ 100 units/mL 3-5 mL. PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5mL.	Quantity: _____ Refills: _____
Hydration: ☐ NS ☐ D5W	IV	Pre: ☐ 500 mL ☐ 1000 mL ☐Other: _____ Concurrent: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ Post: ☐500 mL ☐1000 mL ☐Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐ *Epinephrine* ***nursing requires***	☐ IM ☐ SC	☐ 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) ☐ 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) ☐ 1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	Quantity: _____ Refills: _____
☐ Diphenhydramine Oral	PO	Premedication: ☐ 12.5 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
☐ Diphenhydramine 50 mg/mL vial ***nursing required***	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5 mg-50 mg (15-30 kg) ☐ 25 mg-50 mg (Over 30 kg) If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day) If severe allergic reaction: call 911	Quantity: _____ Refills: _____
☐ Flush Orders:	☐ Peripheral Access ☐ Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush to clear medication from tubing (recommended if no post-hydration) ☐ Other: _____	Send quantity sufficient for medication days supply
☐ Additional Medication: _____	_____ _____	_____ _____	_____ _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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