Enjaymo Enrollment Form

CVS specialty®

Fax Referral To: 1-855-291-1938 **Phone:** 1-844-287-1298

Patient Demographics					
Name:				DOB:	
Address:				Last 4-SSN:	
City, ST Zip:				Language:	
Phone:		Alt. Phone:		Gender:	☐ Male ☐ Female
☐ patient support program info requested					

Prescriber Information			
Prescriber's Name:		State License #	
NPI #:	DEA #:	Group or Hospital:	
Address:		City, State, Zip Code:	
Phone:	Fax:	Contact Person:	Contact's Phone:

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:		Phone:		Policy ID:		Group#:	
Prescription Insurance:		Phone:		Policy ID:		Group#:	
RX BIN#:		RX PCN#:					
☐ Check box if patient is enrolled in manufacturer copay assistance		If yes, please provide ID#:					

Diagnosis and Clinical Information	
Needs by Date:	Ship to: ☐ Patient ☐ Office ☐ Other:
Diagnosis (ICD-10):	
Patient Clinical Information Allergies:_____ Weight: _____lb/kg Height:_____in/cm	
Access:	☐ PIV ☐ CVC/PICC ☐ Port

Has patient already received loading doses – check box to indicate yes and date, or check box for no. ☐ Yes Date: _____ ☐ No

Date of Last infusion: _____

Required Vaccines are complete:

a. Date of Vaccination for Meningitis: _____

b. Date of Vaccination for Pneumococcal: _____

c. ☐ **Please urgently start Enjaymo and vaccinations will be completed as soon as possible**.

Does patient have cardiopulmonary disease? ☐ Yes ☐ No **(If yes, Manufacturer guidelines will be used for total time and/or rates.)**

Nursing: Skilled nursing to provide home infusion per home care protocols and provide IV/port access care, flushing per protocols ☐ Yes ☐ No

Site of Care: ☐ Home Infusion ☐ Prescriber office or other infusion clinic (drug only)

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PRESCRIPTION INFORMATION

MEDICATION / SUPPLIES	STRENGTH	DOSE & DIRECTIONS		QUANTITY/REFILLS
☐ Enjaymo	☐ 50mg/mL	**Step 1**	☐ Administer 6.5 g IV every 2 weeks ☐ Administer 7.5 g IV every 2 weeks	☐ Dispense 28 day supply Refills: _____
		Step 2	☐ Diluted in 500 mL Normal Saline bag (total volume) Dispense: 1000 mL (28 day supply) ☐ Undiluted (total volume 130 mL for 6.5 g dosing OR total volume 150 mL for 7.5 g dosing)	
		Step 3	☐ Infuse via Gravity ☐ Infusion Pump ***Rate per manufacturer guidelines unless otherwise indicated:** **_____mL/hr**	
☐ Normal Saline Flush	0.9%	Flush the line immediately following completion of the infusion with a sufficient quantity (approximately 20 mL) per physician orders		☐ Dispense: PRN 10 mL Syringes
☐ Normal Saline KVO	0.9% 50mL bag	Use to keep vein open or as directed.		☐ Dispense : 100 mL
If patient is PORT or PICC, please specify heparin to dispense:				
☐ Heparin	☐ 10 units/mL ☐ 100 units/mL	Flush the line after infusion per physician orders.		☐ Dispense: PRN 3 mL syringes ☐ Dispense: PRN 5 mL syringes

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

ANAPHYLACTIC ORDERS

☐ Diphenhydramine 50 mg/mL (1 mL/vial) Administer ___ mg slow IVP PRN adverse reactions Dispense: 1 dose.
☐ Solu-Medrol SDV ☐ 40 mg/mL ☐ 125 mg ☐ 500 mg Administer ___ mg IV PRN adverse reactions Dispense: 1 dose
☐ Solu-Cortef SDV ☐ 100 mg ☐ 250 mg ☐ 500 mg Administer ___ mg IV PRN adverse reactions Dispense: 1 dose
☐ Epinephrine Auto-injector 0.3 mg (2-pack) Administer 0.3 mg IM PRN anaphylactic reaction. May repeat in 5-15 minutes as needed. Dispense: 2 pens.

SUPPLIES	STRENGTH	ROUTE	DIRECTIONS
☐ Normal Saline Hydration	0.9% 500 mL/ bag	Bolus IV as needed for hydration due to an adverse reaction	Dispense: 1 bag or _____ ☐ Other (please specify): _____ Dispense PRN or _____

Additional Orders
(If Applicable)

☐ Infusion warmer requested

Medicare requires specification of both Rx signature date and desired therapy start date.
In the following chart, please print clearly the Physician, PA or NP (name, NPI and DEA #) who is authorizing the refills.

Acute Reaction
NURSING PROCEDURE: STOP ANY INFUSION OR MEDICATION ADMINISTRATION IMMEDIATELY.

1. If moderate to severe symptoms occur, activate EMS system and initiate BCLS if indicated.
2. If applicable, caregiver to call 911.
3. Call the physician.
4. Administer AIR medications listed as needed for Acute Infusion Reaction to Enjaymo.
5. If reaction subsides, resume infusion at half previous rate and increase gradually to a rate no greater than previous rate.
6. If reaction does not subside, continue to follow BCLS and contact prescriber for additional medical management.
7. Remain with patient until EMS arrives.

Prescriber signature required (stamp not allowed): Prescriber attests to supervising this patient's medically necessary treatment.

Prescriber Name		NPI		Phone	
State License		DEA		Fax	
Group / Hospital				Contact Person	
Address, City, ST Zip				Contact Phone	

PER NEW YORK LAW, A NEW YORK SERIAL NUMBER IS REQUIRED ON THE PRESCRIPTION – PLEASE CALL US AT 844-287-1298 TO PROVIDE A VERBAL

"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.