Imaavy Enrollment Form

CVS specialty®

Fax Referral To: 1-800-571-3995
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-833-865-1828

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. 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):

☐ G70.00 Myasthenia Gravis without (acute) exacerbation
☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ Other Code: _____Description: _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

Patient to be administered:

☐ Hospital/Clinic
☐ CVS Specialty to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol.
☐ CVS Specialty to coordinate skilled nursing to provide home administration.
☐ Other: _____

Is this a first dose? ☐ Yes ☐ No
If yes, where is the patient to be infused for the first dose? ☐ MD office with MDO staff ☐ Hospital/Clinic
☐ Home by HC nurse ☐ Other: _____
Specialty Pharmacy to coordinate nursing for home care? ☐ Yes ☐ No

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____Patient Phone: _____
Patient Address: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Imaavy	☐ 1200 mg/ 6.5mL (185 mg/mL)	**Initial Dose:** Infuse IV 30mg/kg (Dose = _____mg) over at least 30 minutes once. **Maintenance Dose:** Infuse IV 15mg/kg (Dose = _____mg) over at least 15 minutes every 2 weeks. *Start maintenance dose 2 weeks after the initial dose.	Quantity:_____ Refills:_____

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

Nursing Medications Complete items below, required for Home Infusion

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
☐ 0.9% Sodium Chloride	N/A	Use 0.9% Sodium Chloride Injection, USP, as a diluent to make a total volume to be administered of 125 mL	Quantity Sufficient Refills: PRN
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 PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity Sufficient Refills: PRN
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity:_____ Refills:_____

☐ 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.