Inflammatory Bowel Disease Enrollment Form

Medications A (Avsola)

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com
Coram National Call Center Fax : 1-866-843-3221

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: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____

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):

☐ K50.90 Crohn's Disease, unspecified, without complications ☐ Date of Diagnosis __/___/___
☐ K51.90 Ulcerative colitis, unspecified, without complications ☐ Date of Diagnosis __/___/___
☐ 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 __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

Nursing and Administration:

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
For Remicade/Remicade Biosimilars: First three doses to be given in controlled setting.
*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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Avsola	100 mg vial	☐ 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 ☐ 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: _____

Inflammatory Bowel Disease Enrollment Form
Medications A-H
(Adalimumab-adaz, Adalimumab-fkjp, Cimzia, Entyvio, Hadlima, Hulio)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Adalimumab-adaz (unbranded version of Hyrimoz)	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 40mg SC every other week ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Adalimumab-fkjp (unbranded version of Hulio)	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20mg SC every other week ☐ Inject 40mg SC every week ☐ Inject 80mg SC on Day 1, 40mg Day 15, then 20mg every other week starting Day 29 ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: Inject SC 400 mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks	Quantity: 1 kit (6 prefilled syringes) Refills: 0
☐ Cimzia	☐ 200 mg/1 mL prefilled syringe ☐ 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks	Quantity: _____ 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: _____
☐ Hadlima	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS	☐ Inject 40mg SC every other week ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Hulio	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20mg SC every other week ☐ Inject 40mg SC every other week ☐ Inject 80mg SC on Day 1, 40mg Day 15, then 20mg every other week starting Day 29 ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

Inflammatory Bowel Disease Enrollment Form

Medications H-R (Humira, Hyrimoz, Idacio, Inflectra, Infliximab, Remicade, Renflexis)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

	STRENGTH	DOSE & DIRECTIONS	QUANTITY/ REFILLS
☐ Humira	☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL PFS ☐ 80 mg/0.8 mL Pen	☐ Inject 20 mg SC every week ☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on day 1, 40 mg on day 15, then 20 mg every other week starting Day 29 ☐ Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 20 mg every week starting day 29 ☐ Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 40 mg every other week starting day 29 ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 8, 80 mg day 15, then 80 mg every other week starting on Day 29 ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 8, 80 mg day 15, then 40 mg every week starting on Day 29 ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting on Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Hyrimoz	☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PEN ☐ 80mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 80 mg/0.8 mL PFS (with needle guard) ☐ Pediatric Crohn's Starter Pack (<40kg) ☐ Pediatric Crohn's Starter Pack (≥40kg) ☐ Adult Crohn's and UC Starter Pack (carton of 3)	☐ Inject 20mg SC every other week ☐ Inject 40mg SC every other week ☐ Inject 80mg SC on Day 1, 40mg Day 15, then 20mg every other week starting Day 29 ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Idacio	☐ 40mg/0.8mL PEN ☐ 40mg/0.8mL PFS	☐ Inject 40mg SC every other week ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Inflectra ☐ Infliximab ☐ Remicade ☐ Renflexis	100 mg vial	☐ 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/k (Dose = _____mg) every 8 weeks ☐ 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: _____

Inflammatory Bowel Disease Enrollment Form
Medications R-S
(Rinvoq, Simponi, Skyrizi, Stelara)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Rinvoq	45 mg	Induction Dose: ☐ Take 1 tablet once daily for 8 weeks ☐ Take 1 tablet once daily for 12 weeks	Quantity: _____ Refills: _____
☐ Rinvoq	☐ 15 mg ☐ 30 mg	Maintenance Dose: ☐ Take 1 tablet once daily	Quantity: _____ Refills: _____
☐ Simponi	☐ 100 mg/mL in a single-dose prefilled SmartJect autoinjector ☐ 100 mg/mL in a single-dose prefilled syringe	☐ Induction 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	Quantity: _____ Refills: _____
☐ Skyrizi	☐ 600 mg/10 mL (60 mg/mL) single dose vial ☐ 360 mg/2.4 mL (150 mg/mL) single-dose prefilled cartridge with on-body injector	**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 **Maintenance Dose:** ☐ Inject 360 mg SC week 12 and every 8 weeks thereafter	Quantity: 1 Vial Refills: 0 Quantity: 1 Vial Refills: 0 Quantity: 1 Vial Refills: 0 Quantity: 1 device with prefilled cartridge Refills: _____
☐ Stelara	130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: _____. (This date is needed to determine shipment of Stelara SC maintenance dosage)	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
☐ Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	☐ 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter.	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity:_____ Refills: _____

Inflammatory Bowel Disease Enrollment Form
Medications T-Z
(Tysabri, Xeljanz, Yuflyma, Zeposia)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tysabri	NA	indicate CVS/specialty as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255)	Quantity: 0 Refills: 0
☐ Xeljanz	☐ 5 mg ☐ 10 mg	☐ 10 mg twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily, depending on therapeutic response. Use the lowest effective dose to maintain response. Discontinue Xeljanz after 16 weeks of treatment with 10 mg twice daily if adequate therapeutic benefit is not achieved.	Quantity: _____ Refills: _____
☐ Yuflyma	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL PFS (with safety guard)	☐ Inject 40mg SC every other week ☐ Inject 160mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40mg every other week starting Day 29	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Zeposia	28-day Starter Kit: (Four 0.23mg capsules, three 0.46mg capsules, and one bottle containing twenty-one 0.92mg capsules)	☐ Take 0.23mg capsule orally once daily on days 1-4, then 0.46mg capsule once daily on days 5-7, then 0.92mg capsule once daily starting on day 8 and thereafter.	Quantity: 1 Kit (28-day supply) Refill: 0
☐ Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	☐ Take 0.23mg capsule orally once daily on days 1-4, followed by 0.46mg capsule once daily on days 5-7.	Quantity: 7-day supply Refill: 0
☐ Zeposia	0.92 mg capsules	☐ Take 0.92mg capsule orally once daily.	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

Inflammatory Bowel Disease Enrollment Form
Nursing Orders

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment __/__/____
Is the patient on samples? ☐ No ☐ Yes; If yes, how many samples has patient received? _____
TB Test Date __/___/___ ☐ Positive ☐ Negative ☐ Hepatitis status: _____
Prior therapy, treatment dates, and reason(s) for discontinuation: _____

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 ☐ PICC ☐ CVL	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/CVL - NS 10 mL & Heparin 100 units/mL 3-5 mL and 10 mL sterile saline to access port a cath ☐ PICC - NS 10 mL & Heparin 10 units/mL 3-5 mL	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 required***	☐ 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 mg/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) May repeat in 5-15 minutes as needed PRN severe allergic reaction – 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 (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

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.