Inflammatory Bowel Disease Enrollment Form Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram National Call Center Fax: 1-866-843-3221

		imple Steps to Submitting a Referral	
	ATION (Complete or include		
Patient Name:		DOB: Gender: 🗌 Male 🗌	Female
Address:		City, State, ZIP Code:	
		ovided below) 🗍 Text (to cell # provided below) 🗌 Email (to email pro	vided below)
		a text or email, Specialty Pharmacy will attempt to contact by phone.	
Primary Phone:		Alternate Phone:	
Email:		Last Four of SSN: Primary Language:	
		Relationship to patient:	
2 PRESCRIBER INFO			
Prescriber's Name:		State License #:	
	EA #: Group or Ho		
Address:		City, State, ZIP Code:Contact's Phone:	
3 INSURANCE INFO	RMATION Please fax copy of p	prescription and insurance cards with this form, if available (front and b	ack)
		enrolled or eligible for Medicare/Medicaid? 🗌 Yes 🗌 No	
Policy Holder's Name:_		Policy Holder's DOB: Relationship to Patient:	
Medical Insurance:	Те	elephone: Policy ID: Group #:	
Prescription Insurance	:	Prescription Plan Telephone:	
Policy ID:	Group #: _	Prescription Plan Telephone: RX BIN #: RX PCN #:	
Check box if patient	t is enrolled in manufacturer copa	ay assistance If yes, please provide ID#	
4 DIAGNOSIS AND	CLINICAL INFORMATION		
		Ship to: Patient Office Other:	
Diagnosis (ICD-10):			
	ease, unspecified, without compl		
	olitis, unspecified, without compl		
Other Code:	Description		
Patient Clinical Inform			
Allergies:		□ NKDA Weight: □ kg □ lb Height: □ cm □ in	
		of therapy; Date of last treatment/	
		any samples has patient received?	
		Hepatitis status:	
		ntinuation:	
Nursing and Administ			
		nurse visit as necessary? 🗌 Yes 🗌 No	
		ry Infusion Suite (AIS)* Prescriber's Office** Other Infusion Clin	C
		es to be given in controlled setting.	
		s, Nursing Services for drug administration/therapy teach train.	
	ther infusion Clinic: Drug only to	or facility administration	
**Prescriber's Office/O			
5 PRESCRIPTION	INFORMATION		
**Prescriber's Office/O 5 PRESCRIPTION MEDICATION		DOSE & DIRECTIONS	QUANTITY/REFILLS
5 PRESCRIPTION	INFORMATION STRENGTH	Inject 40 mg SC every other week	Quantity:
5 PRESCRIPTION MEDICATION	INFORMATION STRENGTH 40 mg/0.8 mL PEN		Quantity: 28 days
5 PRESCRIPTION MEDICATION Adalimumab-	INFORMATION STRENGTH	Inject 40 mg SC every other week	Quantity:
5 PRESCRIPTION MEDICATION Adalimumab- aacf	INFORMATION STRENGTH 40 mg/0.8 mL PEN	 Inject 40 mg SC every other week Inject 160 mg SC on Day 1 (given in one day or split over two 	Quantity: 28 days
5 PRESCRIPTION MEDICATION Adalimumab- aacf (unbranded version	INFORMATION STRENGTH 40 mg/0.8 mL PEN	 Inject 40 mg SC every other week Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg SC every other week starting Day 29 	Quantity: 28 days 84 days
5 PRESCRIPTION MEDICATION Adalimumab- aacf (unbranded version	INFORMATION STRENGTH 40 mg/0.8 mL PEN	 Inject 40 mg SC every other week Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg SC every other week starting Day 29 Inject 40 mg SC every other week 	Quantity: 28 days 84 days
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6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

CA, MA, NC & PR: Interchange is mandated unless Prescribe	r writes the words " No Substitution "	ATTN: New York and Iowa providers	s, please submit electronic prescription
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
DAW / May Not Substitute		Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /		May Substitute / Product Selection Permitted /	

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.

CVS specialty[®]

Patient Name: Patient DOB: Patient Phone: Prescriber Name: Prescriber Phone:		Please Complet	e Patient and I	Prescriber Information	
Prescriber Name: Prearriser Plane:			Patient DOB:		
Patient Clinical Information: INKD Weight: Is of plant Is of plant Altergies: Image: Imag	Patient Address:				
Allergies:	_		Pr	escriber Phone:	
Treatment status: we we to therpy: Continuation of therapy: Date of text treatment					· · ·
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TB Tost Date	Is the patient on s	amples? \Box No \Box Yes: If ves, how many	v samples has pat	ient received?	
Prior therapy, treatment dates, and reason(s) for discontinuation: DOSE& DISECTIONS QUANTITY/REFILU MEDICATION STRENCTH DOSE& DISECTIONS QUANTITY/REFILU Adalinumab- 20 mg/0.4 mL PFS Inject 20 mg SC overy veek Quantity: (urbranded 40 mg/0.8 mL PFS Disect 20 mg SC overy veek Quantity: (urbranded 40 mg/0.8 mL PFS Disect 20 mg SC overy veek Quantity: (adainumab- 20 mg/0.4 mL PFS Disect 20 mg SC overy other wook starting Day 29 Prior there are any other wook starting Day 29 (adainumab- 20 mg/0.4 mL PFS Disect 20 mg SC on Day 1 (byten in one day or split over, two consecutive days), 80 mg on Day 15, then 20 mg Control mod Starting Day 29 Quantity: (adainumab- 40 mg/0.8 mL PFN Disect 30 mg SC on Day 1 (byten in one day or split over, two week starting Day 29 Quantity: (adainumab- 40 mg/0.8 mL PFN Dischese (Aduit and Pediatric 2.6 years old) Pd days (adainumab- 100 mg vial Dischese (Aduit Maintanance Dose: Infrae N tas End mg/kg (Dose =mg) at weeks 0, 2, G and every 8 weeks Quantity: Pd days (brance Dose: Infrae N tat End mg/kg (Dose =mg) at weeks 0, 2, G and every 8 weeks Quantity: Litit Pd old org vial (charia	TB Test Date/	/ Positive Negative	Hepatiti	is status:	
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Avsola 100 mg vial Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks 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) Refills:					
□ Avsola 100 mg vial Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks □ Ulcerative Colitis (Adultand Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter # of 100 mg vial(s) Refills:	_				Quantity:
Image: Induction Dose: Induction Dose: Induction Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Refills: Infinition (X dutt and Pediatric ≥ 6 years old) Induction Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Image: Variable (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Infinition (X dutt and Pediatric ≥ 6 years old) Image: Variable (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Infinition (X dutt and Pediatric ≥ 6 years old) Image: Variable (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (X dutt and Pediatric ≥ 6 years old) Infinition (Y dutt) Image: Variable (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (Y dutt) Infinition (Y dutt) Image: Variable (X dutt and Pediatric ≥ 6 years old) Maintenance Dose: Infinition (Y dutt) Infinition (Y dutt) Infinition (Y dutt) Induction Dose: Induction Dose: Induction Dose: Infinition (Y dutt) Infi	🗋 Avsola	100 mg vial			
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 Quantity: 1 kit (Dose =mg) every 8 weeks Induction Dose: Infuse IV at 5 mg/kg (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Refills: 0 (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Refills: 0 (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Quantity: (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Quantity: (Disterative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Quantity: (Disterative Colitis (Adult and Pediatric ≥ 6 years old) [Disterative Colitis (Adult and Pediatric ≥ 6 years old) [Disterative Colitis (Adult and Pediatric ≥ 6 years old) (Disterative Colitis (Adult and Pediatric ≥ 6 years old) [Disterative					- · ·
6 and every 8 weeks thereafter 0 0 0			Induction Dose:		
Image: Second state of the second s			-		
Maintenance Dose: Injust IV at 5 mg/kg (Dose =mg) every 8 weeks Quantity: 1 kit (6 prefilled syringes) Cimzia Cimzia Starter Kit (6 prefilled syringes) Induction Dose: Inject SC 400 mg (2 injections) on day 1, and d weeks 2 and 4. If response occurs, follow with 400 mg every four weeks Quantity: 1 kit (6 prefilled syringes) Cimzia 200 mg/1 mL prefilled syringe 200 mg vial Maintenance Dose: Quantity: Refills: 0 Induction Dose: 1 piect SC 400 mg Quantity: Quantity: Quantity: Quantity: Induction Dose: 1 piect SC 400 mg (2 injections) every 4 weeks Refills: 0 Quantity: Quantity: Induction Dose: 1 response occurs, follow with Quantity: Vails Quantity: So0 mg vial 1 Vial Veek 0: Infusion 300 mg IV 2 Vials Quantity: 1 Vial Week 6: Infusion 300 mg IV Week 8: Infusion 300 mg IV Refills: Quantity: 1 Vial 108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Quantity: 1 Vial Refills: Refills: Refills: Prescriber's Signature: Date: Date: Date: Date: Prescriber's Signature: Date: Date: Date: Date:					
Image: Comparison of Compar					
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 Image: Cimzia 200 mg/1 mL prefilled syringe Maintenance Dose: Inject SC 400 mg Quantity: 1 kit (6 prefilled syringes) Refills: 0 Image: Cimzia 200 mg/1 mL prefilled syringe Maintenance Dose: Inject SC 400 mg Quantity: Image: Cimzia 200 mg vial Maintenance Dose: Inject SC 400 mg Quantity: Image: Cimzia 200 mg vial Maintenance Dose: Quantity: Quantity: Image: Cimzia 300 mg vial Induction Dose: Quantity: Quantity: 1 Vial Image: Cimzia 300 mg vial Induction Dose: Quantity: 1 Vial Image: Cimzia 300 mg vial Induction Dose: Quantity: 1 Vial Image: Cimzia 300 mg vial Induction 300 mg IV Image: Quantity: 1 Vial Image: Cimzia 108 mg/0.68 mL PEN Inject 300 mg IV every 8 weeks Quantity: 2 pens Refills: Quantity: 2 pens Refills: Image: Cimzia 108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Quantity: 2 pens Refills: Prescriber's Signa					
Cimzia Cimzia Starter Kit (6 prefilled syringes) at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks (6 prefilled syringes) Cimzia 200 mg/1 mL prefilled syringe Maintenance Dose: Inject SC 400 mg 200 mg vial Quantity:				· •, · ,	Quantity: 1 kit
400 mg every four weeks Refills: 0 Cimzia 200 mg/1 mL prefilled syringe Maintenance Dose: Inject SC 400 mg Quantity:	🗌 Cimzia	Cimzia Starter Kit (6 prefilled svringes)			• •
Cimzia 200 mg/1 mL prefilled syringe Maintenance Dose: Inject SC 400 mg Quantity:					
Image: Severy 4 weeks Refults:		200 mg/1 mL prefilled syringe			Quantity:
Induction Dose: Induction Dose: Induction Dose: Week 0: Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Week 2: Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Week 6: Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Week 6: Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Infusion 300 mg IV Refills: 0 Maintenance Dose: Quantity: 1 Vial Inject 300 mg IV every 8 weeks Refills: 108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Quantity: 2 pens "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitute Prescriber's Signature: Date: 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		200 mg vial	(2 injections) eve	ery 4 weeks	
Image: Service of the service of th			Induction Dose:		<u> </u>
300 mg vial Week 2: Infusion 300 mg IV Image: Constraint of the second sec			Week 0: Infus	sion 300 mg IV	
Image: Construct of the second sec		300 mg vial		0	
Maintenance Dose: Quantity: 1 Vial Inject 300 mg IV every 8 weeks Refills: 108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Quantity: 2 pens BPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) Quantity: 2 pens "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitute Prescriber's Signature:Date: Date:Date:Date: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	Entyvio		Week 6: Infus	sion 300 mg IV	
108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Quantity: 2 pens Refills: 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) May Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitution Permissible May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:			Maintenance Do	se:	
108 mg/0.68 mL PEN Inject 108 mg SC every 2 weeks Refills: 5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) May Substitute / Product Selection Permitted / Substitute / Product Selection Permitted / Substitution Permissible * Daw / May Not Substitute Date: 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			🗌 Inject 300 mg	g IV every 8 weeks	Refills:
		108 ma/0.68 mL PEN	Inject 108 mg	ISC every 2 weeks	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Prescriber's Signature:					Refills:
DAW / May Not Substitute 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		IIGNATURE REQUIRED (STAMP SIGN	IATURE NOT AL	LOWED)	
Prescriber's Signature: Date: 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			No Substitution /		
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription			Date:		Date
· · · · · · · · · · · · · · · · · · ·					
	CA, MA, NC & PR: Int	•			

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.

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		hatory Bowel Disease Enrollment Form	
		se Complete Patient and Prescriber Information	
Patient Name:		Patient DOB:Patient Phone:	
Patient Address:	·		
Prescriber Name	e:	Prescriber Phone:	
Patient Clinica	l Information:		
Allergies:		NKDA Weight: 🗌 kg 🗌 lb Height: 🗍	cm 🗌 in
Treatment statu	us: 🗌 New to therapy	NKDA Weight: kg lb Height:	
Is the patient or	n samples? 🔲 No 🗌 Yes; If y	yes, how many samples has patient received?	
TB Test Date _	_// 🗌 Positive 🗌 Ne	egative Hepatitis status:	
Prior therapy, ti	reatment dates, and reason(s) for discontinuation:	
5 PRESCRIPTI	ON INFORMATION		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
		🗌 Inject 40 mg SC every other week	
		Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Quantity:
	40 mg/0.4 mL PEN	days), 80 mg on Day 15,	28 days
🗌 Hadlima	40 mg/0.8 mL PEN	then 40 mg every other week starting Day 29	🗌 84 days
	40 mg/0.4 mL PFS	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Refills:
	40 mg/0.8 mL PFS	days), 80 mg on Day 15, then	
		40 mg every other week starting Day 29	
		Inject 20 mg SC every other week	
		Inject 40 mg SC every other week	Quantity:
	20 mg/0.4 mL PFS	Inject 80 mg SC on Day 1, 40 mg Day 15, then 20 mg every other week	28 days
🗌 Hulio	40 mg/0.8 mL PFS	starting Day 29	🗌 84 days
	40 mg/0.8 mL PEN	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	Refills:
		days), 80 mg on Day 15, then	
		40 mg every other week starting Day 29	
		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	
	20 mg/0.2 mL PFS	Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 20 mg	Quantity:
_	40 mg/0.4 mL PFS	every week starting day 29	🗌 28 days
🔄 Humira	40 mg/0.4 mL Pen	Inject 80 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, then 40 mg	🗌 84 days
	80 mg/0.8 mL PFS	every other week starting day 29	Refills:
	🗌 80 mg/0.8 mL Pen	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	
		Inject 40 mg SC every other week	
	40 mg/0.4 mL PEN	Inject 80 mg SC on Day 1, 40mg Day 15, then 20 mg every other week	Quantity:
🗌 Hyrimoz	40 mg/0.4 mL PFS	starting Day 29	28 days
	(with needle guard)	Inject 160 mg SC on Day 1 (given in one day or split over two consecutive	84 days
		days), 80 mg on Day 15, then 40 mg every other week starting Day 29	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 /		May Substitute / Product Selection Permitted /	
DAW / May Not Substitute		Substitution Permissible	
Prescriber's Signature:	Date:	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

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Please Complete Patient and Prescriber Information			
Patient Name		Patient DOB:Patient Phone:Patient Phone:	
Patient Clinical			
		NKDA Weight: 🗌 kg 🗌 lb Height: 🗍	om 🗆 in
Treatment statu	s: New to therapy	NKDA Weight: L kg L lb Height: L c	
Is the natient on	samples? \Box No \Box Yes: If yes he	ow many samples has patient received?	
	$/$ _/ Positive \Box Negative		
		iscontinuation:	
MEDICATION		DOSE & DIRECTIONS	QUANTITY/REFIL
MEDIOATION	GINERATI	Crohn's Disease (Adult and Pediatric \geq 6 years old) Induction Dose:	QOANTITIKEIN
		Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8	
🗌 Inflectra		weeks thereafter	
		Crohn's Disease (Adult)	
		<u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose =mg) every	
🗌 Infliximab		8 weeks	Quantity:
		☐ Crohn's Disease (Pediatric ≥6 years old)	# of 100 mg vial(s)
	100 mg vial	<u>Maintenance Dose</u> : Infuse IV at 5 mg/k (Dose =mg) every	Refills:
🗌 Remicade		8 weeks	
—		\Box Ulcerative Colitis (Adult and Pediatric \geq 6 years old) <u>Induction</u>	
		Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and	
Renflexis		every 8 weeks thereafter	
		\Box Ulcerative Colitis (Adult and Pediatric \geq 6 years old) <u>Maintenance</u>	
		Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks	
		Induction Dose	Quantity:
	☐ 300 mg/15 mL single dose vial	Week 0: Infuse 300 mg via IV infusion over at least 30 minutes	🗌 1 Vial
		Week 4: Infuse 300 mg via IV infusion over at least 30 minutes	2 Vials
		Week 8: Infuse 300 mg via IV infusion over at least 30 minutes	3 Vials
			Refills: 0
		Induction Dose	Quantity:
		Week 0: Infuse 900 mg via IV infusion over at least 30 minutes	3 Vials
Omvoh		Week 4: Infuse 900 mg via IV infusion over at least 30 minutes	6 Vials
		Week 8: Infuse 900 mg via IV infusion over at least 30 minutes	9 Vials Refills: 0
		Maintanana Daga	Remus: U
	2 x 100 mg/mL PEN	Maintenance Dose	
	2 x 100 mg/mL PFS	each) at Week 12 and every 4 weeks thereafter	Quantity:
	1 x 100 mg/mL + 1 x 200 mg/		28 days
	2 mL PEN	Maintenance Dose	☐ 84 days
	1 x 100 mg/mL + 1 x 200 mg/	Inject 300 mg SC (given as two consecutive injections of 100 mg	Refills:
	2 mLPFS	each) at Week 12 and every 4 weeks thereafter	
	130 mg/26 mL (5 mg/mL) IV		Quantity:
	single-dose vial		2 Vials
	Date Infusion was completed or	Single IV Induction Dose:	3 Vials
🗌 Pyzchiva	scheduled: (This date is	55 kg or less 260 mg at Week 0: # of vials to be used 2	4 Vials
	needed to determine shipment	more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3	Refills: 0
	of Stelara SC maintenance	more than 85 kg 520 mg at Week 0: # of vials to be used 4	
	dosage)		
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
🗌 Pyzchiva	SC dose in a single-dose	every 8 weeks thereafter.	Refills:
	prefilled syringe	🗌 Inject 90 mg SC every 8 weeks	
		Induction Dose:	Quantity:
🗌 Rinvoq	45 mg	Take 1 tablet once daily for 8 weeks	Refills:
		Take 1 tablet once daily for 12 weeks	

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

CA MA NC & DP: Interchance is mandated unless Prescriber writes the words "No Substitution"	ATTN: New York and Iowa providers please submit electronic prescription
Prescriber's Signature: Date:	Prescriber's Signature: Date:
DAW / May Not Substitute	Substitution Permissible
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /

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Inflammatory Bowel Disease Enrollment Form

Please Complete Patient and Prescriber Information			
Patient Name:			
_			
		Prescriber Phone:	
Patient Clinical			
Allergies:		NKDA Weight: kg lb Height: ntinuation of therapy; Date of last treatment//	
		many samples has patient received?	
		continuation:	
5 PRESCRIPT MEDICATION	ION INFORMATION STRENGTH	DOSE & DIRECTIONS	OUANTITY /DEFULLS
MEDICATION			QUANTITY/REFILLS
🗌 Rinvoq	│	Maintenance Dose:	Quantity:
		Take 1 tablet once daily	Refills:
	130 mg/26 mL (5 mg/mL) IV single-dose vial	Single IV Induction Dose:	Quantity:
	Date Infusion was completed or	55 kg or less 260 mg at Week 0: # of vials to be used 2	3 Vials
🗌 Selarsdi	scheduled: (This date is	🗌 more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be	4 Vials
	needed to determine shipment of	used 3	Refills: 0
	Stelara SC maintenance dosage)	more than 85 kg 520 mg at Week 0: # of vials to be used 4	Nonas. O
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
Selarsdi	SC dose in a single-dose prefilled	every 8 weeks thereafter.	Refills:
	syringe	Inject 90 mg SC every 8 weeks	
		Inject 40mg SC every other week	Quantity:
Simlandi	40 mg/0.4 mL PEN	Inject 160mg SC on Day 1 (given in one day or split over two	28 days
(adalimumab-	40 mg/0.4 mL PFS	consecutive days), 80 mg on Day 15, then 40mg SC every other	84 days
ryvk)	🗌 80 mg/0.8 mL PEN	week starting Day 29	Refills:
	100 mg/mL in a single-dose	Induction Dose: Inject SC 200 mg initially (given as 2	
🗌 Simponi	prefilled SmartJect autoinjector	subcutaneous injections of 100 mg each) at Week 0, followed by	Quantity:
	100 mg/mL in a single-dose	100 mg at Week 2 and then 100 mg every 4 weeks	Refills:
	prefilled syringe	<u>Maintenance Dose</u> : Inject SC 100 mg every 4 weeks	
		Intravenous CD Induction Dose:	Quantity: <u>1 Vial</u> Refills: <u>0</u>
		Week 0: Infuse 600 mg IV over at least one hour	Quantity: <u>1 Vial</u> Refills: <u>0</u>
		Week 4: Infuse 600 mg IV over at least one hour	Quantity: <u>1 Vial</u> Refills: <u>0</u>
	600 mg/10 mL	Week 8: Infuse 600 mg IV over at least one hour	
	(60 mg/mL) single dose vial	Intravenous UC Induction Dose:	
		Week 0: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
Skyrizi		Week 4: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
	180 mg/1.2 mL (150 mg/mL)	Week 8: Infuse 1,200 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
	single-dose prefilled cartridge	Maintenance UC or CD Dose (Option 1):	Quantity: 1 device with
	with on-body injector	☐ Inject 180 mg SC every 8 weeks	prefilled cartridge
	360 mg/2.4 mL	Maintenance UC or CD Dose (Option 2):	premieu our muge
	(150 mg/mL) single-dose prefilled	☐ Inject 360 mg SC week 12 and every 8 weeks thereafter	Refills:
	cartridge with on-body injector	Inject 360 mg SC every 8 weeks	
	130 mg/26 mL (5 mg/mL) IV		Quantity:
	single-dose vial	Single IV Induction Dose:	2 Vials
	Date Infusion was completed or	55 kg or less 260 mg at Week 0: # of vials to be used 2	3 Vials
Stelara	scheduled: (This date is	more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be	
	needed to determine shipment of	used 3 \square means then 25 km 500 means the Weak 0: the finite to be used 4	Refills: 0
	Stelara SC maintenance dosage)	more than 85 kg 520 mg at Week 0: # of vials to be used 4	
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose, then	Quantity:
🗌 Stelara	SC dose in a single-dose prefilled	every 8 weeks thereafter.	Refills:
	syringe	🗌 Inject 90 mg SC every 8 weeks	

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

CA, MA, NC & PR: Interchange is mandated unless Prescribe	r writes the words " No Substitution "	ATTN: New York and Iowa provide	rs, please submit electronic prescription
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
DAW / May Not Substitute		Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /		May Substitute / Product Selection Permitted /	

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Inflammatory Bowel Disease Enrollment Form

		plete Patient and Prescriber Information			
Patient Name:					
	::				
	Prescriber Name: Prescriber Phone:				
	al Information:				
		🗌 NKDA 🛛 Weight: 🗌 kg 🗌 lb Height:	\Box cm \Box in		
Treatment stat	us: New to therapy	NKDA Weight: kg 🗌 lb Height: ntinuation of therapy; Date of last treatment//			
Is the patient o	n samples? 🗌 No 🗍 Yes; If yes, how	many samples has patient received?			
	_// Positive Negative	Hepatitis status:			
Prior therapy, t	reatment dates, and reason(s) for disc	continuation:			
5 PRESCRIP	TION INFORMATION				
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS		
	130 mg/26 mL (5 mg/mL) IV single-	Single IV Induction Dose:	Quantity:		
	dose vial	55 kg or less 260 mg at Week 0: # of vials to be used 2	2 Vials		
🗌 Steqeyma	Date Infusion was completed or	\square more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 2	🔲 3 Vials		
	scheduled: (This date is	be used 3	4 Vials		
	needed to determine shipment of	\square more than 85 kg 520 mg at Week 0: # of vials to be used 4	Refills: 0		
	Stelara SC maintenance dosage)				
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose,	Quantity:		
🗌 Steqeyma	SC dose in a single-dose prefilled	then every 8 weeks thereafter.	Refills:		
	syringe	Inject 90 mg SC every 8 weeks			
	200 mg/20 mL	Intravenous UC or CD Induction Dose:	Quantity: 1 Vial Refills: 0		
	(10 mg/mL) single-dose vial	Week 0: Infuse 200 mg IV over at least one hour	Quantity: 1 Vial Refills: 0		
		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		
		Subcutaneous CD Induction Dose:	çaanay: i via ricinic. c		
	☐ Induction Pack for Crohn's	Week 0: Inject 400 mg SC at Week 0	Quantity: 1 Pack Refills: 0		
	Disease (2 x 200 mg/2 mL Pens)	Week 4: Inject 400 mg SC at Week 4	Quantity: 1 Pack Refills: 0		
	Disease (2 × 200 mg/2 me Pens)	Week 8: Inject 400 mg SC at Week 8	Quantity: 1 Pack Refills: 0		
Tremfya		Maintenance UC or CD Dose (Option 1):			
		Week 16: Inject 100 mg SC at week 16 and every 8 weeks			
	200 mg/2 mL PEN	thereafter	Quantity: 56 DS Refills: 0		
	200 mg/2 mL PFS	Inject 100 mg SC every 8 weeks	Quantity: 56 DS Refills:		
	100 mg/mL single-dose One-				
	Press patient-controlled injector	Maintenance UC or CD Dose (Option 2):	Quantity: 28 DS Refills: 0		
	100 mg/mL PEN 100 mg/mL PFS	Week 12: Inject 200 mg SC week 12 and every 4 weeks			
			Quantity: 28 DS Refills:		
		Inject 200 mg SC every 4 weeks	Quantity: 84 DS Refills:		
		Please complete a MS TOUCH/Tysabri enrollment form and			
🗌 Tysabri	NA	indicate CVS/specialty as your preferred pharmacy provider.	Quantity: 0		
	NA	(For questions, please contact TOUCH Prescribing Program	Refills: 0		
		at 1-800-456-2255)			
	130 mg/26 mL (5 mg/mL) IV single-	Single IV Induction Dose:	Quantity:		
_	dose vial	55 kg or less 260 mg at Week 0: # of vials to be used 2	2 Vials		
	Date Infusion was completed or	\square more than 55 kg to 85 kg 390 mg at Week 0: # of vials to	3 Vials		
Ustekinumab	scheduled: (This date is	be used 3	4 Vials		
	needed to determine shipment of	more than 85 kg 520 mg at Week 0: # of vials to be used 4	Refills: 0		
	Stelara SC maintenance dosage)				
	90 mg/mL	Inject 90 mg SC 8 weeks after the initial IV induction dose,	Quantity:		
Ustekinumab	SC dose in a single-dose prefilled	then every 8 weeks thereafter.	Refills:		
	syringe	Inject 90 mg SC every 8 weeks	Quantity: Refills:		
Other	Strength:	Dose:	Quantity Relits		

5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary DAW / May Not Substitute Prescriber's Signature:	/ Do Not Substitute / No Substitution /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

CA, MA, NC & PR: Interchange is mandated unless	Prescriber writes the words "No Substitution"	ATTN: New York and Iowa

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.

			Enrollment Form	
	Please Complete	Patient and Press		
Patient Name:		Patient DOB:	Patient Phone:	
Patient Address: _				
Prescriber Name:		Prescrib	er Phone:	
Patient Clinical				
Allergies:		NKDA Weight:	kg 🗌 lb Height: C	m 🗌 in
	s: 🗌 New to therapy 👘 🗌 Continuat	ion of therapy; Date of	last treatment//	
	samples? 🔲 No 🗌 Yes; If yes, how many			
			us:	
	atment dates, and reason(s) for discontinu	ation:		
	ION INFORMATION			1
MEDICATION	STRENGTH	D	DSE & DIRECTIONS	QUANTITY/REFILLS
				Quantity:
U Velsipity	2 mg	Take 1 tablet by m	outh once daily	30 days
		-	-	90 days
			in at least 0 weaks fallowed by E at 10	Refills:
			for at least 8 weeks; followed by 5 or 10 ading on therapeutic response. Use the	Quantity:
🗌 Xeljanz	🔲 5 mg	o i 1	to maintain response.	Refills:
	🗌 10 mg		fter 16 weeks of treatment with 10 mg	Nonus
			e therapeutic benefit is not achieved.	
	130 mg/26 mL (5 mg/mL) IV single-dose		· · ·	Quantity:
	vial	Single IV Induction Do		2 Vials
Yesintek	Date Infusion was completed or		ng at Week 0: # of vials to be used 2 o 85 kg 390 mg at Week 0: # of vials to	3 Vials
resinter	scheduled: (This date is needed	be used 3	0 85 kg 390 mg at week 0. # of viais to	4 Vials
	to determine shipment of Stelara SC	_	20 mg at Week 0: # of vials to be used 4	Refills: 0
	maintenance dosage)		-	
	90 mg/mL		weeks after the initial IV induction dose,	Quantity:
Yesintek	SC dose in a single-dose prefilled syringe	then every 8 weeks th		Refills:
	_	Inject 90 mg SC ev		Quantity
	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS	Inject 40 mg SC ev	легу отпег weeк on Day 1 (given in one day or split over	Quantity: 28 days
🗌 Yuflyma	\square 40 mg/0.4 mL PFS (with safety guard)), 80 mg on Day 15, then 40 mg every	\square 84 days
	\square 80 mg/0.8 mL PEN	other week starting D		Refills:
	28-day Starter Kit: (Four 0.23 mg		sule orally once daily on days 1-4, then	
	capsules, three 0.46 mg capsules, and		e daily on days 5-7, then 0.92 mg	Quantity: 1 Kit (28-day
🗌 Zeposia	one bottle containing twenty-one 0.92 mg	• •	arting on day 8 and thereafter.	supply)
	capsules)			Refill: 0
	7-Day Starter Pack	Take 0.23 mg cap	sule orally once daily on days 1-4,	Quantity: 7-day supply
🗌 Zeposia	(4 capsules of 0.23 mg and 3 capsules of	followed by 0.46 mg o	capsule once daily on days 5-7.	Refill: 0
	0.46 mg)			
Zeposia	0.92 mg capsules	Take 0.92 mg can	sule orally once daily.	Quantity:
				Refills:
				Quantity:
Zymfentra	120 mg/ mL PEN	Maintenance dose on	/ V	28 days
	120 mg/ mL PFS (with needle guard)	120 mg SC once ev	very two weeks	B4 days
				Refills: Quantity:
Other	Strength:	Dose:		Refills:
				Nonao

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do No DAW / May Not Substitute Prescriber's Signature:	ot Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber v	writes the words " No Substitution "	ATTN: New York and Iowa providers,	please submit electronic prescription

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Inflammatory Bowel Disease Enrollment Form Nursing Orders

	Dies	Complete Detient and Dressriber Information	
Datiant Nama:	Plea	se Complete Patient and Prescriber InformationPatient DOB:Patient Phone:Patient Phone:PAtien	
Patient Address:			
Prescriber Name:		Prescriber Phone:	
Patient Clinical Informatio	<u>n:</u>	NKDA Weight: 🗌 kg 🗌 lb Height:	
Allergies:	to thoropy	INKDA Weight: Isg I b Height: Continuation of therapy; Date of last treatment//	
		yes, how many samples has patient received?	
TB Test Date / /		egative Hepatitis status:	
) for discontinuation:	
PRESCRIPTION INFO		**ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE A	T HOME/CORAM AIS**
MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
		Catheter Care/Flush – Only on drug admin days – SASH or PRN to	
		maintain IV access and patency	
Catheter:		PIV: NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days)	Quantity:
	IV	CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL	Refills:
		3-5 mL.	
		PORT: 10 mL sterile saline to access PORT w/ huber needle	
		NS 10 mL & Heparin 100 units/mL 3-5mL.	
			Hydration max infusion
Hydration:		Pre: 500 mL 1000 mL 0ther:	rate mL/hr
	IV	Concurrent: 500 mL 1000 mL 0ther:	(Adult max rate
		Post: 500 mL 1000 mL Other:	250 mL/hr unless
			otherwise indicated)
		1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs)	
Epinephrine	🗌 ІМ	1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs)	Quantity:
nursing requires	□sc	1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg)	Refills:
		Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	
		Premedication:	
Diphenhydramine	PO	12.5 mg/kg (0-30 kg)	Quantity:
Oral	FU	25 mg	Refills:
		50 mg (Over 30 kg)	
		1 mg/kg (under 15 kg)	
Diphenhydramine		12.5 mg-50 mg (15-30 kg)	
50 mg/mL vial	Slow IV	25 mg-50 mg (Over 30 kg)	Quantity:
nursing required		If mild/moderate reaction: may repeat in 3-5 minutes as needed	Refills:
	_	(Adult max dose: 100 mg/day)	
		If severe allergic reaction: call 911	
Access	Peripheral		
	Access	10 mL NS post flush	Send quantity
Flush Orders: Central		50 mL NS post flush	sufficient
	Venous	(recommended if no post-hydration)	for medication days
	Access	Other:	supply
Additional			
Medication:			
Detiont is interacted in patient our	ort programa	STAMD SIGNATURE NOT ALLOWED Application Application Applications	arovidad as pooded for administration

OPRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber's Signature:	Date:	Prescriber's Signature:	_Date:
	B		
DAW / May Not Substitute		Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute	/ No Substitution /	May Substitute / Product Selection Permitted /	

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ______ ATTN: New York and Iowa providers, please submit electronic prescription

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