Lysosomal Storage Disorders Enrollment Form

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com

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: ________________________ Group or Hospital: ____
State License #: _________________________ NPI #: _________________________DEA #: _________________________
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 ☐ Coram Ambulatory Infusion Suite ☐ Other: _______________

Diagnosis (ICD-10):

Date of Diagnosis: _______________

☐ E74.02 Pompe Disease: ☐ Infantile Onset ☐ Late Onset
☐ E75.21 Fabry Disease: Exhibiting clinical signs/symptoms? ☐ Yes ☐ No
☐ E75.22 Gaucher Disease: ☐ Type 1 ☐ Type 2 ☐ Type 3
CYP2D6 Genotype: ☐ Ultra Rapid ☐ Extensive ☐ Intermediate ☐ Poor
☐ E75.24 Niemann-Pick disease, acid sphingomyelinase deficiency (ASMD)
☐ E75.5 Other Lipid Storage Disorders
☐ E76.0 Mucopolysaccharidosis I (MPS I)
☐ E76.1 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
☐ E76.219 Mucopolysaccharidosis IVA (MPS IVA, Moroquio A Syndrome)
☐ E76.29 Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy Syndrome)
☐ Other Code: _______ Description ____________________

Patient Clinical Information:

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

Nursing:

Specialty Pharmacy to coordinate Nursing? ☐ Yes ☐ No Port? ☐ Yes ☐ No
Site of Care: ☐ Physician Office ☐ Infusion Clinic ☐ Outpatient Hospital ☐ Home Infusion ☐ Other: ___________

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Please Complete Patient and Prescriber Information

Patient Name: ____________________ Patient DOB: ____________ Patient Phone: ________________

Patient Address: ____

Prescriber Name: ____________________ Prescriber Phone: ____________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aldurazyme	2.9 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Cerdelga	84 mg capsule	Take 1 capsule ________ time(s) per day.	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Cerezyme	400 unit vial	Dose ________ Units ________ Units / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Elaprase	6 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Elelyso	200 unit vial	Dose ________ Units ________ Units / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Fabrazyme	☐ 5 mg vial ☐ 35 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Kanuma	20 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Lumizyme	50 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Miglustat	100 mg capsule	Take 1 capsule three times per day	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Naglazyme	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
☐ Nexviazyme	100 mg vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Vpriv	400 unit vial	Dose ________ Units ________ Units / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Ramping Required	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months
☐ Vimizim	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
☐ Xenpozyme	20mg Vial	Dose ________ mg ________ mg / kg Body Weight, IV Vol to infuse _______ mL Rate ______ mL Frequency ______ ☐ Escalation Required (Please attach Rx for escalation dose)	Quantity: ____________ Refills: ☐ 12 months ☐ ___ months

☐ 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.

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Nursing Medications

Please Complete Patient and Prescriber Information

Patient Name: ______________________________Patient DOB: _____________Patient Phone:_____________________

Patient Address: ____

Prescriber Name: __________________________________ Prescriber Phone: ________________________________

5 PRESCRIPTION INFORMATION

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
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 (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath
☐ Epinephrine **nursing requires**	☐ 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 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)
☐ Diphenhydramine 50mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)
☐ Other: ___________	Other: _________	Other: ______________________________
☐ Other: ___________	Other: _________	Other: ______________________________
☐ Other: ___________	Other: _________	Other: ______________________________
☐ Other: ___________	Other: _________	Other: ______________________________

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