

Lysosomal Storage Disorders Enrollment Form



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

Phone: 1-800-237-2767



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)

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: _____

Lysosomal Storage Disorders Enrollment Form

Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Aldurazyme	2.9 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Cerdelga	84 mg capsule	Take 1 capsule _____ time(s) per day.	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Cerezyme	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Elaprase	6 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Eleyso	200 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Fabrazyme	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 35 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Kanuma	NA	All referrals must be sent through the HUB, OneSource. Phone: 1-888-765-4747	Quantity: 0 Refills: 0
<input type="checkbox"/> Lumizyme	50 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Miglustat	100 mg capsule	Take 1 capsule three times per day	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Naglazyme	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
<input type="checkbox"/> Nexviazyme	100 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Vpriv	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Ramping Required	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ months
<input type="checkbox"/> Vimizim	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
<input type="checkbox"/> Xenpozyme	20mg Vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ <input type="checkbox"/> Escalation Required (Please attach Rx for escalation dose)	Quantity: _____ Refills: <input type="checkbox"/> 12 months <input type="checkbox"/> __ 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: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 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
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg)
<input type="checkbox"/> Diphenhydramine 50mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____

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

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