Multiple Sclerosis IV/SC Infusion Enrollment Form

CVS specialty®

Fax Referral To: 1-855-592-6890 **Phone:** 1-866-526-4984
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

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: _____ 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 ☐ Coram Ambulatory Infusion Suite ☐ Other: _____

☐ Infusion Site: Name: _____ Address:

_____

(Please include street address, suite #, city, state, ZIP)

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis (MS) ☐ Other Code: _____ Description _____

If MS, please indicate type:

☐ Primary progressive MS (PPMS)
☐ Relapsing-remitting MS (RRMS)
☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No

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

MS drug(s) not able to use:

Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ☐ Yes ☐ No

Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection training not necessary. Date training occurred: _____

Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

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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
☐ Briumvi	150 mg/6 mL vial	Briumvi must be diluted with 0.9% Sodium Chloride Injection 250 mL. ☐ First Infusion: Administer 150 mg (1 vial) IV over 4 hours. ☐ Second Infusion: Administer 450 mg (3 vials) IV over. 1 hour two weeks after the first infusion ☐ Subsequent Infusions: Administer 450 mg (3 vials) IV over 1 hour 24 weeks after the first infusion and every 24 weeks thereafter.	☐ 1 vial ☐ 3 vials ☐ Other: _____ Refills: _____
☐ Lemtrada	NA	Please complete an MS One to One/Lemtrada enrollment form and indicate CVS Specialty as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).	Quantity: 0 Refills: 0
☐ Ocrevus	300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300 mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. ☐ Maintenance: ☐ Infuse 600 mg IV over 2 hours every 6 months. ☐ Infuse 600 mg IV over 3.5 hours every 6 months	Quantity: ☐ 2 vials ☐ Other: _____ Refills: _____
☐ Ocrevus Zunovo	920 mg ocrelizumab and 23,000 units hyaluronidase /23 mL	☐ Administer 23 mL of OCREVUS ZUNOVO subcutaneously in the abdomen over approximately 10 minutes every 6 months	Quantity ☐ 1 vial ☐ Other: _____ Refills: _____
Diluent: ☐ Sodium Chloride	0.9%	Use as directed.	Quantity: ☐ 250 mL (induction) ☐ 500 mL (maintenance) Refills: _____
☐ Tysabri	NA	Please complete an MS Touch/Tysabri enrollment form and indicate CVS Specialty as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).	Quantity: 0 Refills: 0
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
Premed Corticosteroid: ☐ Methylprednisolone ☐ Other: _____	☐ Other: _____	☐ Administer 100 mg IV push approximately 30 min prior to each infusion. ☐ Other: _____	Quantity: _____ Refills: _____
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

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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Please Complete Patient and Prescriber Information

Patient Name: _____Patient DOB: _____Patient Phone:_____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter: ☐ PIV ☐ PORT ☐ CVC/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) CVC/PICC: NS 10 mL & ☐ Heparin 10 units/mL or ☐ 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: _____ Refills: _____
☐Epinephrine **nursing requires**	☐ IM ☐ SC	☐ 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed. For severe allergic reaction also call 911	Quantity: _____ Refills: _____

☐ Patient is interested in patient support program.

Ancillary supplies and kits provided as needed for administration.

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