

# Multiple Sclerosis IV/SC Infusion Enrollment Form



Fax Referral To: 1-855-592-6890 Phone: 1-866-526-4984  
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: \_\_\_\_\_ 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  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  Primary progressive MS (PPMS)

indicate type:  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: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

#### 5 PRESCRIPTION INFORMATION

| MEDICATION   | STRENGTH   | DOSE & DIRECTIONS  | QUANTITY/REFILLS   |
|--|--|--|--|
| <input type="checkbox"/> Briumvi   | 150 mg/6 mL vial   | Briumvi must be diluted with 0.9% Sodium Chloride Injection 250 mL.<br><input type="checkbox"/> First Infusion: Administer 150 mg (1 vial) IV over 4 hours.<br><input type="checkbox"/> Second Infusion: Administer 450 mg (3 vials) IV over 1 hour two weeks after the first infusion<br><input type="checkbox"/> Subsequent Infusions: Administer 450 mg (3 vials) IV over 1 hour 24 weeks after the first infusion and every 24 weeks thereafter. | <input type="checkbox"/> 1 vial<br><input type="checkbox"/> 3 vials<br><input type="checkbox"/> Other: _____<br>Refills: _____ |
| <input type="checkbox"/> 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<br>Refills: 0  |
| <input type="checkbox"/> Ocrevus   | 300 mg/10 mL (30 mg/mL) single dose vial                 | <input type="checkbox"/> <b>Induction:</b> 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.<br><input type="checkbox"/> <b>Maintenance:</b><br><input type="checkbox"/> Infuse 600 mg IV over 2 hours every 6 months.<br><input type="checkbox"/> Infuse 600 mg IV over 3.5 hours every 6 months               | Quantity:<br><input type="checkbox"/> 2 vials<br><input type="checkbox"/> Other: _____<br>Refills: _____                       |
| <input type="checkbox"/> Ocrevus Zunovo  | 920 mg ocrelizumab and 23,000 units hyaluronidase /23 mL | <input type="checkbox"/> Administer 23 mL of OCREVUS ZUNOVO subcutaneously in the abdomen over approximately 10 minutes every 6 months   | Quantity<br><input type="checkbox"/> 1 vial<br><input type="checkbox"/> Other: _____<br>Refills: _____                         |
| Diluent:<br><input type="checkbox"/> Sodium Chloride   | 0.9%   | Use as directed.   | Quantity:<br><input type="checkbox"/> 250 mL (induction)<br><input type="checkbox"/> 500 mL (maintenance)<br>Refills: _____    |
| <input type="checkbox"/> 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<br>Refills: 0  |
| <input type="checkbox"/> Other: _____  | <input type="checkbox"/> Other: _____                    | <input type="checkbox"/> Other: _____  | Quantity: _____<br>Refills: _____  |
| Premed Corticosteroid:<br><input type="checkbox"/> Methylprednisolone<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____                    | <input type="checkbox"/> Administer 100 mg IV push approximately 30 min prior to each infusion.<br><input type="checkbox"/> Other: _____   | Quantity: _____<br>Refills: _____  |
| Premed Antihistamine:<br><input type="checkbox"/> Diphenhydramine<br><input type="checkbox"/> Other: _____     | <input type="checkbox"/> Other: _____                    | <input type="checkbox"/> Other: _____  | Quantity: _____<br>Refills: _____  |

#### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

|  |  |
|--|--|
| "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____                            | May Substitute / Product Selection Permitted / Substitution Permissible<br><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____ |
| <b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " _____ ATTN: <b>New York and Iowa providers</b> , 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: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

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

| MEDICATION/SUPPLIES  | ROUTE  | DOSE/STRENGTH/DIRECTIONS   | QUANTITY/REFILLS                  |
|--|--|--|-----------------------------------|
| Catheter:<br><input type="checkbox"/> PIV <input type="checkbox"/> PORT<br><input type="checkbox"/> CVC/PICC | IV   | Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency.<br>PIV: NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days)<br>CVC/PICC: NS 10 mL & <input type="checkbox"/> Heparin 10 units/mL or <input type="checkbox"/> 100 units/mL 3-5 mL<br>PORT: 10 mL sterile saline to access PORT w/ huber needle<br>NS 10 mL & Heparin 100 units/mL 3-5 mL | Quantity: _____<br>Refills: _____ |
| <input type="checkbox"/> Epinephrine<br>**nursing requires**   | <input type="checkbox"/> IM<br><input type="checkbox"/> SC | <input type="checkbox"/> 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs)<br><input type="checkbox"/> 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs)<br><input type="checkbox"/> 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg)<br>Mild-Moderate Reactions. May repeat in 3-5 minutes as needed.<br>For severe allergic reaction also call 911   | Quantity: _____<br>Refills: _____ |

Patient is interested in patient support program.  
 Ancillary supplies and kits provided as needed for administration.

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|   |  |
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