

<b>1 PATIENT INFORMATION</b>					
First Name: _____	Last Name: _____	DOB: _____	Gender: _____	CVS Acct #: _____	
Address: _____		City: _____	State: _____	ZIP: _____	
Phone: _____	Allergies: _____	Weight: _____ kg	ICD-10: _____		
<input type="checkbox"/> Start of treatment	<input type="checkbox"/> Continuation of therapy	Requested Start Date: _____			

<b>2 PRESCRIBER INFORMATION</b>					
Prescriber Name: _____	Address: _____		City, State, ZIP: _____		
NPI # _____	DEA # _____	Phone: _____	Fax: _____		

<b>3 SERVICE LOCATION – Pick one of the 3 below options (Drug, diluents, supplies, and nursing for drug administration or catheter maintenance)</b>	
<input type="checkbox"/> Home Infusion (Must have first two doses in a controlled setting)	For home infusion, must document date, location and outcome of first two doses: Dose 1 – Date: _____ Location: _____ Outcome: <input type="checkbox"/> Well tolerated <input type="checkbox"/> Tolerated with mild to moderate infusion related reactions (rash, flushing, slowing or temporary interruption of infusion, treatment with antihistamines). Dose 2 – Date: _____ Location: _____ Outcome: <input type="checkbox"/> Well tolerated <input type="checkbox"/> Tolerated with mild to moderate infusion related reactions (rash, flushing, slowing or temporary interruption of infusion, treatment with antihistamines).  <b>** Please note: patients experiencing severe reaction on initial doses are not eligible for home infusion **</b>
<input type="checkbox"/> Drug Only—Infusion will occur at hospital or AIS	

<b>4 PRESCRIPTION INFORMATION</b>				
Medication	Strength	Dose & Directions	Quantity	Refills
Axatilimab-csfr (Niktimvo)	50mg/mL SDV	Infuse 0.3 mg/kg IV over 30 minutes every 2 weeks (maximum dose of 35mg)	Quantity: _____	Refills: _____
		Other: _____	Quantity: _____	Refills: _____

<b>5 Complete below if Home Infusion or AIS administration</b>	
Catheter	<b>Catheter Care</b> – flush only on drug admin days – SASH or PRN to maintain IV access & patency
<input type="checkbox"/> PIV (default if no selection)	<b>PIV</b> – NS 5mL (Heparin 10 units/mL 3-5ml if multiple days)
<input type="checkbox"/> Port	<b>Port</b> – NS 10mL & Heparin 100 units/mL 3-5ml
<input type="checkbox"/> PICC: # Lumens _____	<b>PICC</b> – NS 10mL & Heparin 100 units/mL 3-5mL + Maintenance flushes per lumen
<input type="checkbox"/> Other: _____	
**Give as PIV if Port/PICC failure**	

<b>PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)</b>	
“Dispense As Written” / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  <b>Prescriber’s Signature: _____ Date: _____</b>	May Substitute / Product Selection Permitted / Substitution Permissible  <b>Prescriber’s Signature: _____ Date: _____</b>
Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.	
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.	

<b>1</b>	<b>PATIENT INFORMATION</b>
First Name: _____ Last Name: _____ DOB: _____ Gender: _____ CVS Acct #: _____	

<b>6 PREMEDICATIONS (Home Infusion or AIS administration)</b>			
Medication & Strength	Dose & Directions	Quantity	Refills
Diphenhydramine 25mg capsules	<input type="checkbox"/> 25mg PO 30 minutes prior to infusion <input type="checkbox"/> 50mg PO 30 minutes prior to infusion	Quantity: 1 per infusion Quantity: 2 per infusion	Refills to match prescription(s) above
Acetaminophen 325mg tablets	<input type="checkbox"/> 325mg PO 30 minutes prior to infusion <input type="checkbox"/> 650mg PO 30 minutes prior to infusion	Quantity: 1 per infusion Quantity: 2 per infusion	
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	

**7a ACUTE INFUSION REACTION MEDICATIONS – HOME INFUSION**  
 Fill out below if going to be infused at HOME and patient requires any other medication besides Epinephrine.

Medication & Strength	Dose & Directions	Quantity	Refills
<input type="checkbox"/> Epinephrine autoinjectors	Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Quantity: 2	Refills: 0
<input type="checkbox"/> Epinephrine autoinjectors	Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Quantity: 2	Refills: 0
**Pharmacy to determine dose based on patient weight (above). Leave on file if patient has in-date epinephrine on hand**			
Medication: _____	Directions: _____	Quantity: _____	Refills to match prescription(s) above
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	

**7b ACUTE INFUSION REACTION MEDICATIONS – AIS (AIS will provide drug and supplies for the below if MD prescribes)**  
 Fill out below if going to be infused at AIS and patient requires any other medication besides Epinephrine:

Medication & Strength	Dose & Directions	Quantity	Refills
<input type="checkbox"/> Epinephrine 1mg/mL amp (1:1000)	Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes		Refills to match prescriptions(s) above
<input type="checkbox"/> Epinephrine 1mg/mL amp (1:1000)	Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes		
**AIS to determine dose based on patient weight (above)**			
<input type="checkbox"/> Diphenhydramine 50mg/1mL vial	Directions: _____		Refills to match prescriptions(s) above
<input type="checkbox"/> Diphenhydramine oral Liquid 12.5mg/5mL	Directions: _____		
<input type="checkbox"/> Acetaminophen oral	Directions: _____		
<input type="checkbox"/> Methylprednisolone univial (adult) 125mg	Directions: _____		
<input type="checkbox"/> Methylprednisolone univial (pediatric) 40mg	Directions: _____		
<input type="checkbox"/> NaCl 0.9% 10mL PFS	Directions: _____		
<input type="checkbox"/> 500mL NS with rate flow admin set	Directions: _____		
<input type="checkbox"/> Hydrocortisone univial (adult) 250mg	Directions: _____		
<input type="checkbox"/> Hydrocortisone univial (pediatric) 100mg	Directions: _____		

**PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

“Dispense As Written” / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
<b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____	<b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.

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.

<b>1</b>	<b>PATIENT INFORMATION</b>			
First Name: _____		Last Name: _____		DOB: _____
			Gender: _____	CVS Acct #: _____

<b>8</b>	<b>PREPARATION AND ADMINISTRATION</b>
<b>Intravenous:</b>	
<ul style="list-style-type: none"> <li>• Prior to administration, verify AIR medications are available at the site of infusion</li> <li>• Note that patients are at risk of an infusion reaction with each infusion. AIR medications are required</li> <li>• Validate patient's weight and review potential adverse reactions with patient</li> <li>• Do not begin preparation until IV access has been established and or patency confirmed</li> <li>• Venous Access - Peripheral unless otherwise specified in manufacturer information or patient has pre-existing central access</li> <li>• Oral- Validate that premedications have been taken prior to mixing medication</li> <li>• Injectable- Validate all injectable premedications are available and ready to administer prior to mixing medication</li> <li>• Refer to manufacturer guidelines for filtering and administration device information</li> <li>• Determine the dose and total volume of Niktimvo solution needed</li> <li>• Withdraw the calculated volume of Niktimvo from the vial</li> <li>• Dilute in sterile 0.9% Sodium Chloride to a final concentration of 0.24mg/mL to 0.75mg/mL</li> <li>• Administer diluted Niktimvo solution as an intravenous infusion over 30 minutes through a dedicated infusion line that includes a sterile, low protein binding 0.2 micron in-line or add-on PES filter. Do not administer as an intravenous push or bolus</li> <li>• After the infusion is complete, flush with sterile 0.9% Sodium Chloride Injection</li> </ul>	

**Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration/catheter maintenance and nursing services for drug administration/therapy teach train or catheter maintenance.**

**IF HOME INFUSION – all drugs and supplies including pump if needed is sent.**

**IF AIS INFUSION –No AIR medications are needed to be sent. Send all other supplies including any premeds to AIS.**

**If pump is required for infusion - no pump is needed to be sent– only send 1) Curlin tubing 2) Pump sheet to nursing homecare to send with these orders**

**Additional Notes:** \_\_\_\_\_

<b>PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)</b>	
“Dispense As Written” / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
<b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____	<b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____
Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.	
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.	

**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members’ private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.